Delaware Medical Journal

ESTABLISHED 1776 — 1789 INCORPORATED

Official Publication of the Medical Society of Delaware

OCTOBER, 1961 . . .

THE CASE FOR HOSPITAL MERGER

IN CERTAIN MENINGEAL INFECTIONS effective cerebrospinal fluid levels— effective antibacterial action

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

In the management of certain meningeal infections, CHLOROMYCETIN offers unique advantages. It has been described by one investigator as "...the best chemotherapeutic agent for patients with *H. influenzae* meningitis...."[1] In comparative *in vitro* studies,[2] CHLOROMYCETIN showed the "highest effectiveness" against *Hemophilus influenzae, Diplococcus pneumoniae,* streptococcus, and numerous other pathogens. Another report states: "Chloramphenicol is regularly detected in the cerebrospinal fluid when blood levels greater than 10 micrograms per ml. are reached."[3] Blood levels of this magnitude are easily attainable with the administration of CHLOROMYCETIN by either the oral or parenteral routes.

CHLOROMYCETIN effectively penetrates the blood-brain barrier;[3-6] provides effective action against *H. influenzae*[1-4,7-9] and other invaders of the meninges.[5,7,10,11] Product forms are available for administration by the intravenous, intramuscular, and oral routes. For these reasons, CHLOROMYCETIN has contributed conspicuously to the dramatic drop in mortality rates in meningeal infections caused by *H. influenzae* and other susceptible microorganisms.

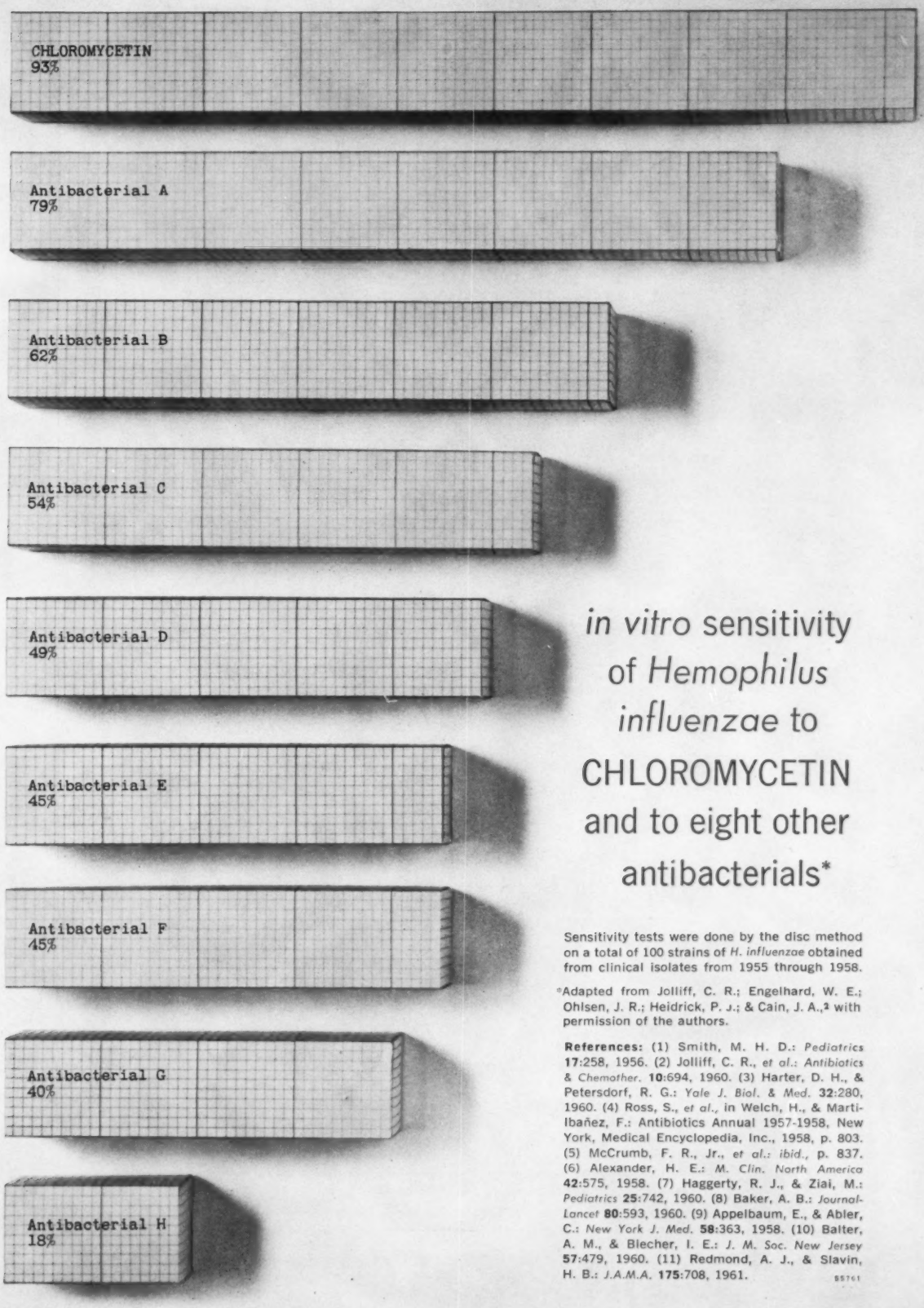
CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan



in vitro sensitivity of *Hemophilus influenzae* to CHLOROMYCETIN and to eight other antibacterials*

Sensitivity tests were done by the disc method on a total of 100 strains of *H. influenzae* obtained from clinical isolates from 1955 through 1958.

*Adapted from Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J.; & Cain, J. A.,[2] with permission of the authors.

References: (1) Smith, M. H. D.: *Pediatrics* **17**:258, 1956. (2) Jolliff, C. R., *et al.*: *Antibiotics & Chemother.* **10**:694, 1960. (3) Harter, D. H., & Petersdorf, R. G.: *Yale J. Biol. & Med.* **32**:280, 1960. (4) Ross, S., *et al.*, in Welch, H., & Martí-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 803. (5) McCrumb, F. R., Jr., *et al.*: *ibid.*, p. 837. (6) Alexander, H. E.: *M. Clin. North America* **42**:575, 1958. (7) Haggerty, R. J., & Ziai, M.: *Pediatrics* **25**:742, 1960. (8) Baker, A. B.: *Journal-Lancet* **80**:593, 1960. (9) Appelbaum, E., & Abler, C.: *New York J. Med.* **58**:363, 1958. (10) Balter, A. M., & Blecher, I. E.: *J. M. Soc. New Jersey* **57**:479, 1960. (11) Redmond, A. J., & Slavin, H. B.: *J.A.M.A.* **175**:708, 1961.

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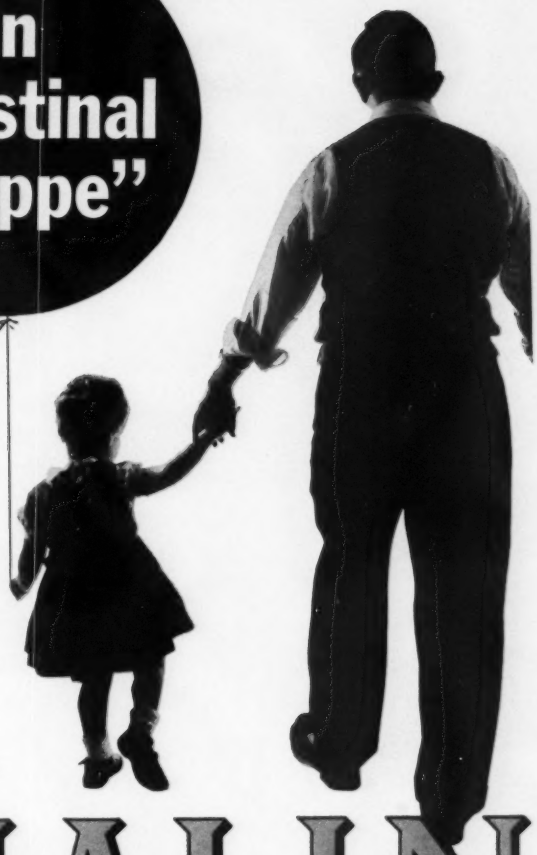
CONTENTS

Entered as second-class matter June 28, 1929, at the Post Office at Wilmington, Delaware, under the Act of March 3, 1879.

In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



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TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

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SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

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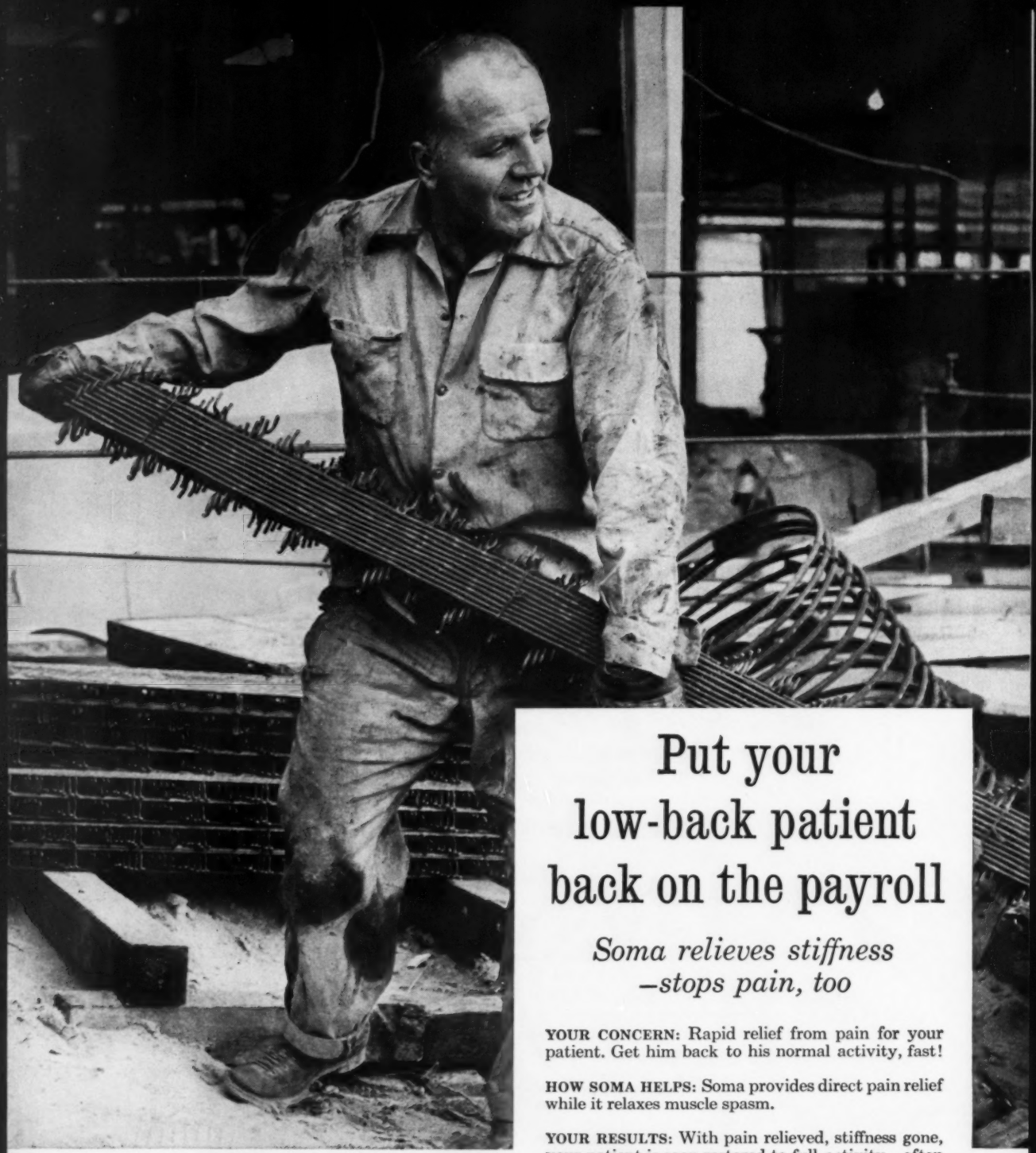


Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

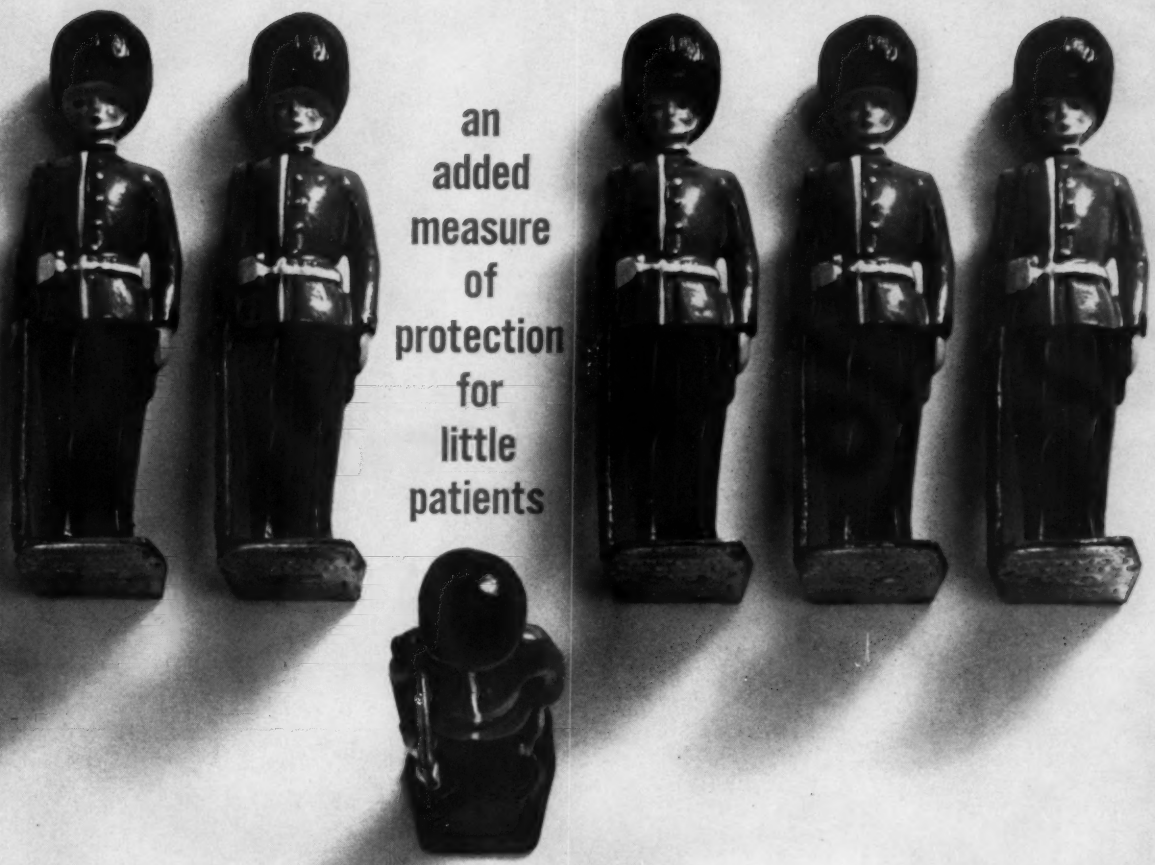
Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



an added measure of protection for little patients

against relapse
against "problem" pathogens

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

pediatric drops
syrup

● full antibiotic activity ● lower milligram intake per dose ● up to 6 days' activity with 4 days' dosage ● uniformly high, sustained peak activity ■ **syrup** (cherry-flavored), 75 mg./5 cc. tsp., bottles of 2 and 16 fl. oz. Dosage: 3 to 6 mg./lb./day—in four divided doses. **pediatric drops,** 60 mg./cc., 3 mg./drop, 10 cc. bottles with calibrated dropper. Dosage: 1 to 2 drops/lb./day—in four divided doses.

PRECAUTIONS: As with many other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs discontinue medication. Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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PLAN NOW to ATTEND the A.M.A. CLINICAL SESSION in DENVER, NOV. 27-30

Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

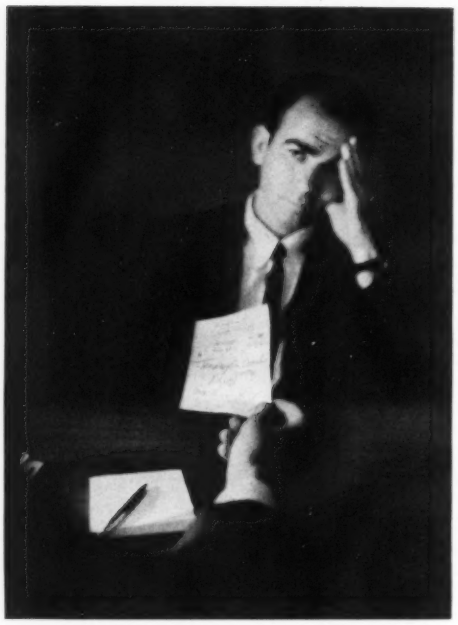
It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

According to a recent report* on the effectiveness of Terramycin in 106 cases of upper respiratory tract infection: "The response in sinusitis was particularly gratifying, as both acute and chronic cases were controlled within an average of five days."

"It was the impression of the hospital staff that oxytetracycline [Terramycin] was not only better tolerated, but more effective than other antibiotics habitually used."

The results reported in this and many other studies confirm the vitality of Terramycin for broad-spectrum antibiotic therapy and demonstrate why —increasingly—the trend is to Terramycin.



In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

More detailed professional information available on request.

another reason why the trend is to Terramycin—*versatility of dosage form:*

TERRAMYCIN Syrup/Pediatric Drops

125 mg. per tsp. and 5 mg. per drop (100 mg./cc.), respectively—deliciously fruit-flavored aqueous forms . . . preconstituted for ready oral administration

TERRAMYCIN Intramuscular Solution

50 mg./cc. in 10 cc. vials; 100 mg. and 250 mg. in 2 cc. ampules—the broad-spectrum antibiotic for immediate intramuscular injection . . . conveniently preconstituted . . . notably well tolerated at injection site with low tissue reaction compared to other broad-spectrum antibiotics

Terramycin®

OXYTETRACYCLINE WITH GLUCOSAMINE

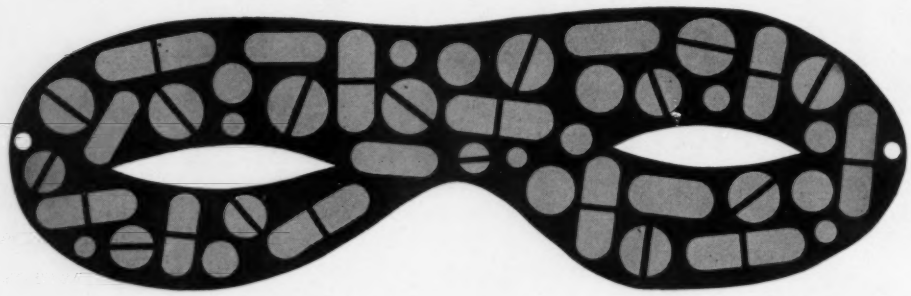
CAPSULES *250 mg. and 125 mg. per capsule*

convenient initial or maintenance therapy in adults and older children

Science for the world's well-being® Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, N. Y.

*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.



drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia SK&F

without steroids this arthritic miner might still be spoon-fed

On METICORTEN, he has worked steadily for six years with no serious side effects

J. G.'s rheumatoid arthritis started in 1949 with severe and unremitting pain in his shoulders. Later, his wrists, elbows, feet and hands became involved with swelling and loss of function. By 1951, when he was 45, the patient was helpless and had to be fed and dressed by his wife. He was frequently hospitalized during the next three years. Hydrocortisone failed to make any change in his condition.

On April 2, 1955, the patient was placed on METICORTEN and improved promptly. Two weeks later he stated, "I feel very well now." He was able to go back to work as a mine electrician that year and had no difficulty driving a car.

For the past six years, he has been maintained on METICORTEN 5 mg. two or three times a day. There have been no side effects. The patient has not lost any work time, nor has he had to limit his activities in any way.

Case history courtesy of Joel Goldman, M.D., Johnstown, Pa.
These photographs of Dr. Goldman's patient were taken on November 10, 1960.

METICORTEN,® brand of prednisone.

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S-783

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OCTOBER, 1961
VOLUME 33
NUMBER 10

THE CASE FOR HOSPITAL MERGER†

• A proposal for easing the problem of hospital care in New Castle County is presented in this analysis of hospital administration, the medical profession and community medical problems. The author's suggesting a merger of several hospitals into one medical center is prompted by his strong sense of community responsibility as a physician and as a native Wilmingtonian.

NORMAN L. CANNON, M.D.

A crisis is facing the hospitals of Wilmington. This crisis is not wholly unique but rather represents part of a national problem. The crisis as it presents itself is characterized by mounting costs of medical care, increased costs for the care of charity patients, increased demands for the facilities provided by the hospitals, increasing utilization of the existing facilities by the patients and by the doctors. This results in increasing deficits which are no longer made up by voluntary contributions from wealthy benefactors and which are not balanced, as they should be, by increased appropriations from State, County and City governments. The crisis in the hospitals has been intensified by the general inflationary spiral in our economy and the possibility of unionization by hospital employees. The crisis is further aggravated by the efforts of the three non-sectarian hospitals to maintain standards of accreditation in the face of an intern shortage and difficulties in providing adequate teaching and training programs to the house staff by the attending staff. The crisis, as it faces the hospitals in Wilmington, applies to all of them.*

The crisis to which I have been referring is, therefore, viewed as a financial crisis affecting patient care, hospital administration, the medical profession, the community. It arises out of the community's desire to have available for its use the best possible medical services. The crisis, therefore, is not solely the affair of any one hospital. It is a community problem and its solution demands a community approach. And although this crisis may not be unique to Wilmington, the proposed solution may be.

† First presented at Memorial Hospital Staff Meeting.

Dr. Cannon is Director of Urology Service, Wilmington General Hospital; Chief of Urology, St. Francis and Delaware Hospitals and Consultant in Urology to A. I. du Pont Institute and Delaware State Hospital, Farnhurst.

* For the purposes of this article, however, the discussion will be confined to the three non-sectarian hospitals, since the proposal to be presented apparently can only be worked out among these three. The St. Francis Hospital may possibly benefit from some loose association within the framework of this proposal but such details would have to be worked out later. The Riverside Osteopathic Hospital is also not included in this proposal for at present association between osteopathic and allopathic hospitals and physicians is not sanctioned by the American Medical Association.

Signs And Symptoms

Let us examine the three non-sectarian hospitals in Wilmington as if one were examining three patients, all showing similar signs and symptoms suggesting that they all may be suffering from the same disease. An enumeration and description of these signs and symptoms is our first consideration. The three hospitals are of approximately the same size in terms of bed capacity and physical plant. The slight variations between them are statistically negligible. They each provide general hospital services for acute medical and surgical care, pediatric, obstetrical and emergency room care with appropriate diagnostic and therapeutic facilities for approximately three hundred patients in each hospital. The hospitals are all located in the City of Wilmington and geographically are perhaps within a mile of each other, certainly not more than ten minutes' driving time from each other in any direction. The type of patients within the hospitals is approximately the same. The hospitals all care for a complete range of medical conditions with an occasional specialization of services in one over the other. Essentially each one attempts to provide a complete spectrum of medical services necessary to the community. The administrative organization is approximately identical in each of the hospitals. Furthermore, close analysis of the membership of the Boards of Directors in the three hospitals reveals an interesting fact, which is that the persons themselves on the Boards of Directors represent a certain powerful segment of the community, powerful in terms of economic strength as they represent certain of the wealthiest families in the City as well as the large industrial units and banking interests. Thus the DuPont Company, the Hercules Powder Company, Atlas Powder Company and the families who are primarily responsible for these companies are well represented on all three Hospital Boards. There is also a family relationship between a number of persons on the Boards of the three non-sectarian hospitals.

This close relationship among the Boards of Directors is in a sense paralleled by the composition of the medical staffs of the three hospitals. By this I do not mean that there is actually a relationship between the staff of one hospital and the other. What I do mean is that, of the approximately three hundred doctors in active practice in Wilmington, almost all of the doctors who are on the staffs of one of the three hospitals occupy active or courtesy positions on all the other hospital staffs. The professional status may vary so that an interest in one hospital may be evident by a Chiefship or Directorship of a service and at the same time the particular doctor will carry courtesy or lesser privileges at another hospital. A review of the staff lists with their respective appointments shows that in practically all instances and with very few exceptions, the membership of the three hospital staffs is identical and that the doctors actually practice in all three hospitals as their needs require it.

Duplications - Administrative

All three hospitals operate accredited schools of nursing; all three hospitals conduct clinics for charity patients; all three hospitals strive to maintain standards of accreditation as determined by the Joint Commission on the Accreditation of Hospitals. All three hospitals have intern and residency training programs; all three hospitals have building programs of one sort or another; all three hospitals are engaged continuously in fund raising and all three hospitals have annual deficits.

A more detailed examination of our hospitals reveals further striking similarities in the problem and the symtomatology. For instance, the three hospitals have the same contract with Blue Cross. This regulates the Blue Cross rates which the hospitals accept in terms of their contracts, and any change in rates is reflected by a joint action of the three hospitals rather than by independent action. Furthermore, charges for various services at the different hospitals are usually worked out jointly up or down so that no appreciable difference exists in

room rates, x-ray charges, laboratory fees or fees for use of operating rooms, anesthesia fees, fees for nursing service, salaries for nurses, salaries for interns and residents and salaries for employees on various levels. Each hospital, despite the fact that it is apparently a distinct, independent unit, is confronted with the same cost problem from top to bottom.

Duplications - Professional

The Joint Commission on Accreditation of Hospitals has set up standards for the government of the medical staff in terms of by-laws, in terms of committee structure, in terms of standards of medical records, in terms of standards of medical performance. Therefore each hospital, with slight variations, has gradually taken on an appearance in its professional structure, very much like the standard suggested by the Joint Commission on Accreditation of Hospitals. This means that all three hospitals, in their efforts to maintain accreditation, must conform by and large to the standards set by the Joint Commission. With the almost complete identity of the medical staffs, this means that the standards of medical practice in the three non-sectarian hospitals are practically identical. What we have in Wilmington are three hundred doctors who circulate among the three non-sectarian hospitals, occupying different positions in the different hospitals but practicing according to the same standards in all three. This fact leads to other problems which quickly become evident.

In caring for a patient and in trying to admit a patient to the hospital, the choice of the patient and the doctor are balanced in some manner with the availability of hospital beds at the time requested. If a bed is not available at a particular hospital, the doctor exercises his privileges in the other hospitals and shops around until he finds a bed sooner, depending on the urgency of the clinical problem. This professional mobility and associated patient mobility has led to the necessity for each hospital to provide duplicate services for the use of its professional staff. This in turn has led to rising costs of operation and overhead, particularly when full utilization of a particular service or piece of equipment cannot occur when the professional staff and clinical load for a specific service is diluted among the three hospitals.

Striking Examples

There are several striking examples of this. One has to do with the five thousand dollar cystoscopic table which each of the hospitals has purchased for the use of its urologists and in no one hospital is this table receiving maximum utilization. To my knowledge, certain special dermatomes for use in skin grafting have been purchased by each of the hospitals for a particular surgeon and yet in each hospital the dermatome is not receiving full utilization. Neurosurgical equipment has been purchased by each hospital for the use of the neurosurgeons without, I am sure, full utilization commensurate with its cost. Now that the Wilmington General Hospital has a cobalt therapy machine, I am sure the pressure is mounting at the Memorial and Delaware Hospitals for the purchase of similar high voltage x-ray equipment, regardless of whether or not the community has a need for three cobalt machines. This constant expansion of services, this constant duplication of services, this constant expenditure and increase in overhead in an effort to have each hospital provide within itself all the services necessary for the care of its patients is helping to drive the hospitals into bigger deficits and straining the capacity of its staff. Other areas where this problem is evident have to do with the maintenance of clinic outpatient services. Each hospital operates outpatient clinics for charity patients who have been or who may become house patients, requiring space, nursing facilities, and staff participation, despite the particular case load which may exist. Examination of the clinic loads in the three non-sectarian hospitals reveals that certain clinics are overburdened in one hospital and practically nil in another one, but nomially and ostensibly a clinic is maintained, a staff man is in attendance, time spent,

records kept, even though the patient load in the particular clinic may be ridiculously small.

Two Groups Involved

There are two special groups of people involved in the crisis now confronting the three non-sectarian hospitals in Wilmington. One group is the administrative staffs and the other group is the professional medical staff. The administrative staffs, including the Boards of Directors, are faced with rising costs, mounting deficits, problems of labor, problems of accreditation, problems of purchasing, problems of housekeeping, problems of nursing schools, such mundane problems as laundry, food supply, cleaning, depreciation, maintenance, expansion plans, and all the manifold complexities of operating a community hospital. The professional staff, on the other hand, has the problem of caring for the patients, seeking the best available facilities for such care as well as demanding new facilities when these become available and desirable. The professional staff, in addition to its medical responsibilities to the patient and its relations with the hospitals, with insurance carriers and Blue Cross, is also concerned with its own internal organization and its self-government within the hospital framework. This involves staff organization, by-laws, staff committees, staff medical education, education of the house staff and itself. It became obvious, several years ago, that a staff meeting at each hospital once a month was putting an unbearable burden on the time of the doctors in the community and a joint arrangement was worked out whereby each hospital would hold only four meetings a year, thereby lightening the burden. However, each department in each hospital has its own staff meeting at frequent intervals, sometimes as often as once a week, sometimes only once a month.

This is in addition to required committee meetings such as Records, Tissue, Education, Formulary, Executive, House Staff, Program, Laboratory, Medical Research, Emergency Room, Radiation, etc. The committee burden on professional staff among the three hospitals, when taken in the framework of County Society committees, Academy of Medicine committees and State Society committees often spreads the available time to the thinness of an ineffective veneer. Therefore when demands are made on the various doctors on the attending staffs of the three hospitals for time to be devoted to intern and resident training, attendance at clinics, time spent in the operating room with residents, it becomes evident that there is not an adequate reservoir of capable, interested physicians to maintain a first-rate teaching program and first-rate clinic coverage in all three hospitals. There may be enough to maintain a teaching program in one hospital but when the demands are made that each hospital maintain an equally adequate program, then the results fall far below the desired goal.

The Proposal

What exists in our Wilmington hospitals today can best be described in terms of the corner grocery, where each small grocery store carries a limited stock, a little bit of many things but not quite everything, and struggles to maintain by its tradition and history of service to the neighborhood an adequate service as best it can. But the old corner grocery store has been gradually disappearing in the face of the giant supermarket, which by its huge purchasing potential, by its mass marketing methods, by its better organization, is able to provide the customer with the best and the most of everything usually at a cheaper price to the consumer.

From an economic standpoint and from a professional standpoint it would seem that the logical solution of the common problems of the Wilmington hospitals is their merger into a Wilmington Delaware Memorial Medical Center. This would combine the three non-sectarian hospitals into a single operating unit with what I believe would be significant advantages to the patients, to the community and to the doctors, and would solve many of the most pressing problems now confronting the

medical community in Wilmington. While there may be some disadvantages to such a merger, I believe the many advantages far outweigh the few disadvantages. I will deal first with the objections that might be anticipated and then with the advantages, as they appear to me and as they would function to resolve the crisis confronting the hospitals and the doctors today.

Possible Objections To Merger

In any proposal, changing the status quo and particularly a merger such as I am suggesting in this presentation, certain people on professional and administrative levels would find or seem to feel on first reaction that this medical center would work to their respective disadvantages. Members of the Boards of Directors might feel that they would lose some of their status in a merged Board. Certainly the individual hospital administrators might wonder what would happen to them, since it is obvious that three hospital administrators would not function as a troika but that one would be the top man. In the various professional departments the directors of surgery, anesthesia, x-ray, laboratory, etc., might also feel that merger offers a threat to their seniority and standing.

The three schools of nursing, when merged, would confront the various directors of nursing and other personnel with thoughts about their status and might suggest at first that such a merger would be to their personal detriment. This normally subjective point of view would in all probability create some of the same type of resistance as was and has been evident in the efforts of the Federal Government to amalgamate the various Armed Services into a single unified service. In addition to this very real problem which, I believe, can be resolved, and which I submit is not a valid objection on the merits, the idea of a merger is further complicated by an intangible quality of loyalty and interest in a particular hospital, generated and nurtured over many years of association by lay people in the community as well as by professional personnel who have dedicated most of their time to the service of one institution to the relative exclusion of the others. Some initial trauma to this loyalty would be inevitable in a merger of the three hospitals.

Another possible objection would be the elimination of what has been described as competition among the three non-sectarian hospitals. It has been expressed by some that this competition is a healthy thing in the community and that by merging the three hospitals the elimination of this competition would stagnate the medical community. To this I can only say that the inter-hospital competition, where it has existed, has been partly responsible for the present crisis and that our primary competitive objective should be to provide medical services to the community equal to or better than medical services which may be available in neighboring cities.

Large Centers Provide The Best

Only by a cooperative effort in a medical center can the best medical care be provided to the community on a level nearing that which is available in the large medical centers of Philadelphia, Baltimore, New York and Washington. Throughout the country, with rare and conspicuous exception, the best medical care is provided in the large centers rather than in small hospitals. Bigness is not of itself detrimental. More and more medical care is becoming a cooperative effort, cooperative between doctor and hospital, between doctor and doctor. Competition between three small hospitals can only result in wasteful effort. Furthermore, the doctors cannot compete with themselves. The true competitive position of a large medical center as is envisaged in this presentation would be vastly enhanced in terms of the relationship of medical care available to the citizens of Wilmington and Northern Delaware as against medical care available in nearby cities. Furthermore, although the St. Francis Hospital, by its very nature, is not wholly amenable to amalgamation in such a medical center, it would probably benefit from some association with a medical cen-

ter in Wilmington; at the same time it would serve as an out-side conscience to any grandiose pretentions which a medical center might develop were it allowed to exist by itself.

Loyalties Are Not Divided

The matter of loyalties and the loss of status which certain persons might feel would result from such a merger into a medical center, seems to me an exaggerated problem which careful planning and preparation should largely eliminate. Among the professional staff, as was pointed out earlier, most of the doctors are on all the hospital staffs so a matter of loyalty to any one hospital represents perhaps an inconsequential reason for sending patients to one place rather than another. As far as the loyalties of the community at large are concerned, most doctors know and most hospital statistics will show that patients will go almost anywhere the doctor suggests. Patients are transferred back and forth depending on bed needs and available facilities for particular use. As far as the loyalties of the Boards of Directors of the three hospitals are concerned, it was pointed out previously that the personnel and makeup of these Boards represents in essence a very closely-knit group of people joined by financial, occupational and family ties. The loyalties indicated by their associations on one board and not another are probably more matters of election and convenience than deep-seated exclusive loyalties engendered by anything more than accident of association.

Without naming names or tracing family relationships, the simple scanning of the names and their positions in community affairs will reveal how closely related the several Boards of Directors actually are. The loss of status which might be threatened by a merger into a medical center could be largely resolved, and there may be a few exceptions, by a system of rotating authority, assignment of professional privileges and job classification with assignment to duties, commensurate with present status so that in the larger organization of a medical center, everyone now functioning in top or near top positions would continue to occupy them with equal responsibility and equal financial reward, with the added satisfaction of greater or better service There may be other objections of which I am not aware and these would be a basis for further discussion of this problem before any effective action in the direction of a merger or the formation of a medical center could be carried out. Certainly the best basis for a successful merger lies in the informed consent and approval of both the medical and administrative staffs of the three hospitals concerned.

Advantages Of Merger

The advantages of a merger of the three hospitals into a medical center are so numerous and so overpowering that it is difficult to know where to commence their enumeration. They can be roughly divided into advantages to the professional staff and to administration and to the community.

To the medical staff it would mean that there would be one medical staff instead of three with one set of by-laws instead of three, with one set of committees instead of three, with one way of doing things in the center instead of three ways of doing things as the doctors circulate across the town. The chart records for the doctors and nurses would be uniform. The procedures would be uniform. The personnel and personnel practices would be uniform. The doctors would certainly, in such a merger, arrange for all the general surgery to be done at one unit and all the urology located in another place, the obstetrics would be centralized, the pediatrics would be centralized and the medical cases would be located at one place. The distribution of different types of medical problems would be centralized, each to its own place so that medical care in the best and fullest degree could be afforded to the larger number of patients available under a medical center program.

What is envisaged is no present change in the physical plants as they now exist but

merely their designation as units 1, 2 and 3 of a medical center. In unit 1 would be located certain of the services, in unit 2 other services and in unit 3 the remaining services. Because of the geographical propinquity of the three units it would be very simple to transfer patients from one unit to another by means of ambulances for the specific service required in the other unit. This would be much simpler than triplicating all the services with the additional cost to each hospital for maintaining such services.

Better Educational Programs

Such arrangements of patient grouping in a medical center would immediately open the way for a better educational program and more complete utilization of the professional staff in such a program. One large internship and residency program, possible affiliated with a university in Philadelphia, should prove more attractive to American medical graduates and improve the house staff procurement potential. There would be one director of medical education instead of three; there would be one internship and residency training program for the center rather than three. The number of patients available in different areas for training purposes, for clinic services, would be substantially increased and consequently would be more productive in terms of educational results. Certainly the dermatologist who has a clinic at each of the three hospitals for various months of the year would be much happier conducting one central dermatologic clinic for the center with a consolidated patient load than he would be conducting three small clinics which trebles his time committments without proportionately greater clinical demands.. This applies to many other of the clinic specialties now being offered in small quantities by each of the three hospitals.

What this would also mean to the doctor in terms of valuable time saved from committee meetings, staff meetings, departmental meetings, is most important and would certainly be a much more effective utilization of professional time in a medical center than diluted as it is now among the three hospitals. Furthermore, the doctor who now shops for beds in the various hospitals faced with delays because surgical beds are tied up in one hospital or pediatric beds are tied up in another, would in a medical center setup know that all the availble beds were being utilized to their fullest and if a shortage of beds exists he would have only one authority to consult in an effort to increase bed capacity where needs arise.

A medical center with a unified professional staff would also be in a better position to police its own activities through its by-laws, through its disciplinary committee, since privileges would be more important to the individual doctor than under the present setup where one doctor or another, for personal reasons, for reasons valid or otherwise, may switch his associations from one place to another if he feels that he is being slighted or unfairly treated. The self-discipline of the doctors would be more effective in a medical center.

Manifold Advantages

The advantages to the administration are manifold also and would seem almost too obvious to enumerate. However, for the sake of completeness, some mention must be made of the advantages. From an economic point of view one medical center would mean one standard of administrative practice. This includes one purchasing division, three times the size of what is now purchasing potential of any one hospital. It would mean one laundry facility and one maintenance facility for the center. It would mean a reduction of duplicate professional services in terms of laboratory, x-ray, anesthesia and other diagnostic and therapeutic facilities for the center.

Still further advantages to the administration might be mentioned in terms of a central admitting office, which would have instant figures available to the physician as well as to the administration on the available bed capacity at any given moment throughout the City. Central records were

already mentioned; a central business office for financial control of the payments to the hospital with central credit control would be a more efficient arrangement. With a medical center with one Board of Directors, we would have one strong bargaining unit with Blue Cross and one medical bargaining unit in terms of its relationship with the Joint Commission on Accreditation of Hospitals or with the Levy Court or with the State Legislature. The statistical data provided by a medical center would be more economic and more efficient and more productive of knowledge and improve the care of the patients since the use of data processing equipment would be feasible in a large medical center where it is not in a small community hospital.

Some Duplication Necessary

This does not mean that all facilities will be centralized or that no facilities will require duplication, since in the very nature of hospital practice, it is necessary to have some laboratory facilities in different units and an operating room available in each unit and certain x-ray facilities also duplicated. However, by and large, there will be no immediate need for three cobalt machines. There will be no need for four Young Cystoscopic tables. There will be no need for three complete sets of urologic cystoscopes. There will be no need for expensive electroencephalographic equipment in each hospital. There will be no need for duplicating gastroscopes or duplicate instruments for otologic surgery or for neurosurgery or for skin grafting equipment and a host of other expensive instruments which are now in triplicate throughout the community. The savings inherent in this merger should be immediately obvious.

One Large Nursing School

The nursing schools would be consolidated into one large nursing school with the resultant augmentation of facilities and increase in the size of classes to a more efficient level with improvement in the number and the quality of teaching facilities, both in personnel and equipment. The hospital record rooms will be consolidated so that a patient in the center will have one clinical record rather than a clinical record scattered among the three hospitals, no one of which may be complete and without which completion the medical care may sometimes be faulty because of a lack of recorded continuity.

The concentration of services possible under a medical center organization would be more efficient and less expensive to the hospitals and to the community. Improvements in medical services in a medical center would be more effectively executed. Emergency room care would certainly be centralized to one unit of the center, since as has been pointed out before, the geographical relation of the three hospitals now lends itself to the designation of one place for emergency services just as another may be designated for general surgery and a third for obstetrics. Private patients and service patients can also be grouped, depending on the best judgment of the qualified people who will determine how these facilities are to be used. The professional staff would certainly be more efficiently used under this arrangement with less physical wear and tear as is now necessary in the daily shuttling back and forth from one hospital to another.

Community Advantages

Planning for future hospital growth in the community, for future expansion, for building programs, for development in areas of research, and other fields where expansion will become desirable, can be coordinated and most efficiently planned from one medical center rather than anarchistically developed with less regard to overall community needs. Thus the proposed Delaware Hospital expansion program involving over fifteen million dollars and the recent expansions of the Memorial and Wilmington General Hospitals would have been better executed had they been carried out as a part of a medical center. The community would receive much more for its dollar had a medical center been in operation before these buildings programs were instituted.

Certainly a medical center in terms of the possibility of a medical school for the University of Delaware would be a more effective institution and in a stronger position to function than three small independent community hospitals. In planning a medical center, furthermore, the needs of the entire community including Northern Delaware could be better served. Additional facilities under the auspices of the center could be planned as the need arises with efficiency and minimum waste.

Preliminary Steps

A step in this direction has already been taken by the formation of a Board of Review as announced in the Wilmington newspapers August 22, where the three non-sectarian hospitals sponsored this organization for the purpose of reviewing expansion plans of the individual hospitals involved in the light of the needs of the community and the facilities already existing in other hospitals. The Board will be free, according to the newspaper, to investigate any other phases of hospital management. This will include such matters as the training of nurses, graduate education of physicians, duplication of hospital facilities and methods of meeting the cost of charity services. It can be seen from this newspaper report that some thought along the lines indicated by this presentation have already entered the minds of the Boards of Directors of the three hospitals. The idea of a Board of Review has opened the door to the concept of merger. Even though its capacity is only advisory it offers the possibiliy of directing the three hospitals gradually toward a course leading to merger. It should be clear, however, that the basic solution to the crisis now confronting the hospitals in Wilmington cannot be solved by a Board of Review alone. A more complete and total approach to the problem must be taken.

Conclusion

I would propose, therefore, that the medical staffs of the three non-sectarian hospitals in Wilmington meet, either separately or jointly, to discuss this proposal and that if, after due consideration, they decide that such a merger into a medical center is in their best interests and would offer the best medical care for the citizens of Wilmington, that the medical staffs recommend to their respective Boards of Directors the advisability of such a merger and urge their favorable consideration.

Under such a merger all the doctors now on the medical staffs of the three hospitals should be guaranteed active membership in the medical center. In such a medical center the doctors would have to be qualified to practice medicine in the State of Delaware and members in good standing in the New Castle County Medical Society. The medical center, through its Credentials Committee, would be responsible for the privileges accorded the doctors on its staff but because of the size of the medical center and because of its possible monopolistic and exclusive character, no doctor should be excluded from the staff of the medical center without demonstrable good cause or without an open hearing.

In my opinion the potential for good to the medical profession and to the community both in the quality of medical care and in the savings inherent in a medical center far outweigh the possible objections which may be raised against it. A medical center formed by the merger of the three non-sectarian hospitals in Wilmington offeres the best solution to all of the problems now besetting the three non-sectarian hospitals in Wilmington. Exploratory steps in this direction have already been taken and there is a climate of opinion receptive to this idea.

It now remains for the medical community to take an active interest in developing this idea and for the Boards of Directors of the three hospitals to take a fresh look at the situation as it now exists and be willing to examine a new proposal objectively and with farsighted vision. A solution to the crisis now confronting the hospitals does not seem evident under the present organizational setup. The situation

calls for curative, not palliative surgery. It would seem that the Boards of Directors, as astute and community minded business men looking at the economic problems confronting the three hospitals, would immediately seize upon the idea of a merger into a medical center as a logical solution to the current crisis. If the impetus in this direction comes from the medical profession itself I would not anticipate that real or valid obstacles would be raised by the Boards of Directors. I submit, therefore, as a modest proposal for solving the problems now confronting the hospitals and the medical profession in New Castle that the three nonsectarian hospitals merge into a medical center for the more efficient and effective care of patients in New Castle County.

CURRICULUM

FOR DELAWARE TWO-WAY RADIO MEDICAL CONFERENCES

NOVEMBER, 1961 SCHEDULE

TOPIC AND FACULTY

October 31 "Food Allergies, First Year of Life." George Blumstein, M.D., Associate Professor of Medicine, Temple University School of Medicine

November 7 "Lipemia and Arterial Disease." Peter T. Kuo, M.D., Associa Professor of Medicine, School of Medicine of the University of Pennsylvania.

November 14 "Inborn Errors of Metabolism." George D. Ludwig, M.D., Assistant Professor Medicine, Hospital of University of Pennsylvania

November 28 "Use and Abuse of Digitalis." Louis R. Dinon, M.D., Assisant Instructor of Medicine, University of Pennsylvania School of Medicine

DISCUSSION

of Dr. Cannon's Article

LEWIS B. FLINN, M.D.

Dr. Cannon's analysis of the present crisis facing the hospitals in Wilmington is well presented, carefully thought out, and deserves serious consideration. I question the sub-title *A Modest Proposal.* To put in effect this proposal in its entirety would be Herculean rather than modest. However, it has great merit and the objectives are sound. Even if agreement could be reached into the near future, I am sure that Dr. Cannon agrees that implementation must be done in stages. Consolidation of the nursing schools is already under serious and urgent consideration.

I cannot agree with Dr. Cannon, however, that this crisis is mainly and primarily a financial crisis. There is, indeed, a financial crisis not to be minimized as he so ably explains, but still more important—there is a medical educational crisis! What profit is there in consolidating hospital service, reducing costs, developing more efficient hospital business administration if the quality of the patient care suffers? For deteriorate it will unless patient care is made our primary purpose. The key to progressive improvement in patient care and the calibre of medical practice in the several hospitals and in the community is effective and progressive medical education of house staff *and* visiting staff. Improved facilities are important, but we cannot wait for them. Candidates for hospital house staff are vitally interested in the educational opportunities that are provided. Medical school teaching has trained them to believe that post-graduate education is desirable, necessary and to be expected. Unfortunately, all too few practicing physicians are interested in this vital educational program. Others are very much interested and enthusiastic but are not equipped to undertake teaching assignments themselves. This state of affairs results in a possible faculty of comparatively few individuals. It is imperative, however, that these few be used to the best advantage for the benefit of the three hospitals concerned and for the community. It cannot be emphasized too strongly that such a faculty properly organized and given proper encouragement and adequate facilities is essential to continuing growth and stimulation of our practicing physicians even if it should unfortunately happen that we should have no house staff. The various advantages in consolidation in other areas of hospital activity, as Dr. Cannon points out, are generally desirable, and if carried out would augment and facilitate this education expansion. However, the educational re-organization can be started at once if the professional staff will accept the idea and then agree to negotiate, and if the staffs and Boards of Trustees understand that such re-organization will require additional funds.

A few statistics may serve to pinpoint the problem. The figures given are very approximate, but even if there is some error the situation is, I think, made very clear.

Dr. Flinn is Director of the Department of Medicine, Delaware Hospital, Wilmington.

Table I indicates the number of discharges for the year 1960 on the four major services in the three hospitals. The number at the Delaware Hospital is somewhat greater in medicine and surgery and in non-surgical pediatrics and especially in certain surgical sub-specialties, but in general the totals are remarkably similar. Table II, however, very strikingly indicates the tremendous differences in the number of service cases. The very great preponderance of clinic patients at the Delaware Hospital becomes evident and if the figures were broken down further the large number of specialty clinics involved would be demonstrated. Emergency room service is also very unequal. Table III points up the fact that those qualified to take an active part in teaching are comparatively few and these few are now spread so widely and overlap so extensively on two or more hospital staffs that their teaching effectiveness is jeopardized and their strength and enthusiasm are waning. It seems imperative, therefore, that representatives of the professional staff of each hospital should confer in the immediate future to make every effort to solve this dilemma.

TABLE I

IN PATIENTS — 1960

			Delaware	*Memorial*			*Wilm. Gen.*
Medicine			2578				2173
Surgery	Gen.	1903					
	Gyn.	1719			Gyn.	849	
	Neuro.	404					
	Other	1874			Other	3984	
			6000				4833
Med. & Surgery			8578	6653			7006
Obstetrics			2649	2398			2377
Pediatrics	All children		2070	2002			?
	Non-surgical		911	?			366

TABLE II

OUT PATIENTS — 1960

CLINIC VISITS — 1960		EMERGENCY DEPT. VISITS — 1960	
Delaware Hospital	29,934	Delaware Hospital	25,793
Memorial Hospital	16,150	Memorial Hospital	15,340
Wilmington General Hospital	9,076	Wilmington General Hospital	17,540

NUMBER OF SERVICE BEDS FOR IN-PATIENTS — 1960

	Medicine	*Surgery*	*Ob-Gyn*	*Pediatrics*
Delaware Hospital	18	34	13	42
Memorial Hospital	12	12	12*	12
Wilmington General Hospital	4	4	4	4

* *Gyn service beds are combined with surgery service beds.*

NOTE—*All hospitals stated that the number of patients admitted will exceed the number of "alloted" service beds.*

TABLE III

ACTIVE STAFF MEMBERS

		Home Hospitals			
Internal Medicine		*Delaware*	*Memorial*	*Wilm. Gen.*	*Other*
Delaware Hospital	41 Internists	32	9	0	
Memorial Hospital	24 Internists	11	13	0	
Wilmington General	17 Internists	11	4	1	1
Surgery					
Delaware Hospital	19	15	1	2	1
Memorial Hospital	15	4	9	2	
Wilmington General	19	10	6	2	1
Obstetrics and Gynecology					
Delaware Hospital	20	16	1	3	
Memorial Hospital	9	4	4	1	
Wilmington General	15	5	0	10	
Pediatrics					
Delaware Hospital	22	19	1	2	
Memorial Hospital	9	8	1	0	
Wilmington General	10	8	0	2	

FELLOWSHIPS EXTENDED

Foreign Fellowships for medical students, sponsored by Smith Kline and French Laboratories, have been extended through 1963. The unique program, which offers future American physicians an opportunity for medical study in underdeveloped areas of the world, is again being offered to junior and senior students in US medical schools. Write to: Dr. Ward Darley, Executive Director of the Association, 2530 Ridge Avenue, Evanston, Ill.

UNILATERAL MEMBRANOUS CONJUNCTIVITIS IN INFECTIOUS MONONUCLEOSIS

• The oculoglandular complex has been described with several infectious diseases particularly tularemia and cat scratch disease. Apparently from this case and a similar case reported in the Norweigian literature, it can be a rare manifestation of infectious mononucleosis.

WILLIFORD EPPES, M.D.

We have recently had occasion to treat a patient for severe unilateral membranous conjunctivitis associated with all usual clinical features of infectious mononucleosis. A review of the American literature on this subject failed to reveal similar cases. Conjunctival injection and edema is a usual sign in infectious mononucleosis and certain types of true conjunctivitis are frequently described. The description of a unilateral, dry, granular conjunctivitis in 8 to 9% of causes by Guthrie and Pessel[1] is most often quoted in American review articles on this subject.[2,3] Descriptions of follicular conjunctivitis in infectious mononucleosis have usually come from other countries.[4,5,6,7,8,9] Falkenberg[10] in Norway carefully described a case of unilateral membranous conjunctivitis at first mistaken for diphtheria but later proved due to infectious monoucleosis. This case closely resembles that of Falkenburg. The apparent rarity of this striking picture prompted publication of this case report.

Case History

The patient, a 31 year old man, first noticed an enlarging tender node in front of the right ear on March 30, 1956. The right eye became inflamed and itched as the node enlarged. During the following week, the lymph nodes in the right side of the neck enlarged. A scratchy throat, feverishness, headache, and fatigue were also noted. Penicillin was given with little effect. Hospitalization was advised on April 11, 1956, because of increasing right conjunctivitis, generalized lymphodenopathy, fever, and malaise.

There was no history of exposure to conjunctivitis or other infectious diseases. There had been no contact with wild rabbits or ticks. The patient's wife, children, and house cat were well.

Physical examination on the 13th day of illness revealed a temperature of 99.6 Fahrenheit, normal pulse and blood pressure. He did not appear severely ill. The lids of the right eye were swollen. There was diffuse reddening of the bulbar conjunctiva but little exudate. The palpebral conjunctiva of the lower lid was markedly edematous and pink in color without granularity. The cornea, iris ,and fundus were normal. The left eye was normal and examination of the ears, nose, and throat revealed no abnormalities. There was a firm, tender, pre-auricular node on the right about 3 cm. in diameter and producing

Dr. Eppes is certified by the American Board of Internal Medicine and is in private practice in Newark, Delaware.

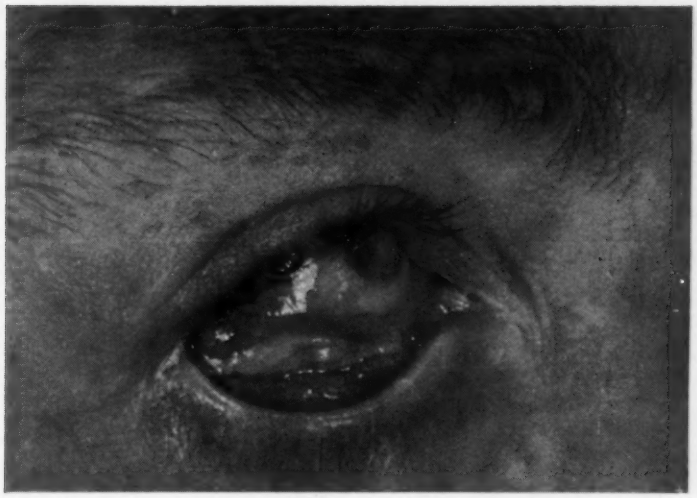

FIGURE I

visable distortion of the face. Many almond-sized nodes were palpable in the right posterior cervical chain. Pea-sized nodes were felt in the left side of the neck and in both axillae. The remainder of the physical examination was normal.

The conjunctivitis progressed and became hemorrhagic (Figure 1). There was no spread to the opposite eye. By the 8th hospital day a membrane appeared in the right lower fornex. This progressed to a dense white adherent membrane which remained about one week then became loose and was removed for microscopic study. At this time the spleen became palpable and temperature which had ranged from 99 to 102° daily subsided.

Laboratory examinations showed a normal urine and normal values of hemoglobin and hematocrit. Chest x-ray was normal. Table No. 1 lists repeated laboratory results according to date.

In addition to the above, liver function studies showed 4+ cephalin flocculation in 24 hours, thymol turbidity 7 units, B.S.P. 5% retention in 45 minutes. Smears from the right conjunctiva showed initially few gram positive cocci, and cultures grew staph aureus. Examination of the membrane removed from the right conjunctiva on 4-28-56 showed fibrin, many monocytic cells, and a few gram positive rods resembling diphtheroids. Intra-dermal testing with cat scratch antigen of Daniels gave no reaction and aggutinations for tularemia were negative. Serum was persistently

TABLE I

	4-12-56	4-16-56	4-19-56	5-1	5-11
W.B.C.	12,000	7,400	18,800		
% Neutrophils	62	30	26		
% Lymphocytes	36	66	74		
% Atypical	?	60	80		
V.D.R.L.	Pes 1:2		Neg		
Heterophile Antibody Unabsorbed		1:224	1:112	1:112	1:56
Guinea Pig absorption		1:56	1:112	1:56	No titre
Beef Red Cell Absorption		No titre	No titre		

negative for complement fixing antibody to the RI group of viruses.

After removal of the sloughing conjunctival membrane, healing proceeded rapidly. Signs of systemic infection and adenopathy disappeared. The patient seemed completely recovered on observation one month after admission.

Discussion And Conclusion

Judging from the single previous report of unilateral membranous conjunctivits, it is likely that this is a rare and unimportant clinical manifestation in infectious mononucleosis. The case may serve to substantiate the opinion of those who feel infectious mononucleosis is truly a disease of protean manifestations. It seems reasonable to assume that the initial oculoglandular complex in this case is quite similar to the pharyngoglandular complex frequently seen when infectious mononucleosis presents with a pharyngeal membrane. It is possible that these mucous membrane lesions represent a portal of entry of the causative agent of infectious mononucleosis.

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SAFETY CHECK LIST

A safety check list, entitled *"Is Your Child Safe"?* has been designed as a public service by the National Society for Crippled Children and Adults to help parents protect and educate their small children against crippling home accidents. Free copies of this list may be obtained from the Delaware Chapter in Wilmington.

HYPOGLYCEMIA DUE TO INSULIN

A Major Medical Problem

• **Emphasis on over-treatment with insulin has been made recently by Danowski, Sindoni and Somogyi. The author stresses the fact that a more effective treatment of diabetes mellitus can be conducted on a conservative clinical basis using the laboratory as an aid rather than a guide.**

EDWARD M. BOHAN, M.D.

Sir Frederick Banting once told a Chicago audience: "We do not know whence ideas come, but the importance of an idea in medical research cannot be overestimated. From the nature of things, ideas do not come from prosperity, affluence and contentment, but rather from the blackness of despair, not in the bright light of day, nor the footlight's glare, but rather in the quiet undisturbed hours of midnight or early morning, when one can be alone to think. These are the grandest hours of all, when the imagination is allowed to run riot on the problem that blocks the progress of research."

On August 14, 1921, the first insulin shock was recorded by Best[1] while working with Banting on a dog. Dog 92 was the first to suffer insulin shock. The blood sugar was intentionally lowered from 220 mgm. per 100 cc of blood to the hypoglycemic figure of 60 mgm. A note was made that the animal with the low blood sugar appeared much brighter after the administration of glucose.

Later on in their work, Banting[1] and his associates observed that sufficiently large doses of insulin produced in rabbits severe convulsions, which were generally fatal if not controlled by the administration of glucose. Due to the severity of these reactions, the original unit of insulin, known as the Toronto Unit, was diminshed in strength by two-thirds, permitting greater latitude in prescribing the remedy.

A close friend of Dr. Banting's[1] Dr. Joseph A. Gilchrist, a diabetic since 1916, was placed on insulin on May 15, 1922, thus becoming the principal human rabbit in the purification of insulin. Gilchrist unluckily once experienced an insulin reaction on a Toronto street and was arrested on a charge of intoxication.

Unfortunately, the same arrests for intoxication are being made forty years later. Our interest in insulin shock must extend further than the portals of medicine. We doctors must go into the highways and byways to educate and inform the public and its responsible representatives concerning the similarity of the symptoms of insulin shock to other diseases, including alcoholism.

Reactions To Insulin

Reactions to insulin occur:

1. *If the blood sugar drops rapidly*

Under these circumstances, shock may occur at 100 mgm. or higher.

Dr. Bohan is Chief of Medicine and Metabolism, St. Francis Hospital, and past president of the Delaware Diabetes Association.

2. *If the blood sugar reaches a low level*

Values less than 50 mgm. can rarely be tolerated without symptoms.

Exceptions may occur, e.g., hypoglycemia induced by the slow action of protamine zinc insulin. Due to the slowness of development of this hypoglycemia, blood sugar may be even lower than 50 mgm. and the patient walking around. This is not so likely to occur with NPH, Lente, or globin insulin.

Insulin reactions are more likely to occur:

1. *If the patients are over-treated with insulin*

This is quite common, especially when repeated attempts are made to create a sugar-free urine. Hypoglycemia may occur which is followed by a compensatory hyperglycemia and glycosuria. Then more insulin is given, and the patient shocks again This is known as over-treatment with insulin.[2]

The Brittle Diabetic

Some diabetic patients are better undertreated. Uusually, the brittle diabetic is best treated in a clinical fashion by asking how he feels and not by treating the laboratory results per se. Glycemia should be correlated with a sense of well-being.

Diabetics vary in their tolerance to hypoglycemia, but frequent insulin shock should be avoided at all costs. No proven harm can be done with a moderate hyperglycemia or glycosuria in a patient who observes the rules of good diabetic conduct, e.g., 170 mg. to 250 mg. two hours post-prandially.

2. *If the patients are sensitive to insulin*

Sensitivity to insulin is more common in the thin or juvenile type of diabetes or in the hard to control diabetic, often known as "brittle" or "fragile" diabetic. In some patients, the change of 2 to 3 units may precipitate shock. All diabetic patients should carry identification, preferably wrist bands or bracelets. The severe type of diabetes mellitus should be labelled as such. (The Delaware Diabetes Association[3] is always anxious to furnish information concerning these methods of identification of the diabetic.)

3. *If meals and diet plan are irregular or inadequate*

Those who "cheat" need more supervision, more education, and more frequent office visits to keep them in line. Those with emotional problems need psychologic adjustment. Most of the diabetics in this category need less insulin and more diet.

4. *If nausea and vomiting occur*

A problem of undernutrition results which may be due to acidosis or can precipitate acidosis and diabetic coma. Nausea and vomiting can be treated with sweetened liquids, or, if it continues, intravenous glucose to cover the daily insulin doses which never should be omitted entirely. In a recent case treated at St. Francis Hospital,[4] because of the repeated swing from acidosis and hyperglycemia to hypoglycemia and insulin shock, Glucagon was administered along with insulin in an effort to stabilize the patient. This combination of Glucagon and insulin seemed to benefit the patient.

5: *If repeated injections are given into the same site*

A system of injection sites should be set up on a daily basis: down one arm for one week, one leg for the next week, up the other leg the next week, up the other arm the following week, and so on. The abdomen may be chosen as an alternate site. This regular and orderly method of administration of insulin insures against ever injecting insulin into the same site.

Pathology Of Hypoglycemia

Repeated severe insulin shocks or profound hypoglycemia may cause pathologic disturbance in many parts of the body. The brain is often the target site, and cerebral edema, petechial hemorrhages, or cellular damage with cell degeneration may occur.

Another system that is the target of insulin shock is the vascular system, and a cerebral accident, coronary occlusion, or other blood vessel pathology may be aggravated or precipitated by insulin shock. While other systems of the body are affected

by hypoglycemia, the more serious target points are the brain and vascular system. Fortunately, the sympathetic nervous system reacts first and sets up a primary defense for these essential organs.

The Symptoms Of Hypoglycemia

A great variety of hypoglycemia symptoms occur, depending on: a.) sensitivity to insulin, b.) the type of insulin and the amount given, c.) the system of the body which is the primary target: this may depend on the speed at which the sugar drops.

The sympathetic nervous system responds with hunger, sweating, nervousness, tremor, and pallor. These symptoms are readily recognized by the patient and doctor, and treated with sweetened drinks, candy, or sugar in some form.

The insulin-sensitive individual may go suddenly into unconsciousness, and the sympathetic nervous system symptoms may be missed with this individual. Certain types of insulin, especially protamine zinc insulin and NPH may cause hypoglycemia symptoms affecting the central nervous system directly. Lack of ambition, depression, drowsiness, headache, nausea, paresthesia, blurring of vision, diplopia, disorientation, amnesia, unconsciousness, and even convulsions, may occur. These symptoms may need treatment with a) Glucagon or b) 50 cc of 50% Glucose intravenously. Both may be needed if the attack is severe. Sugar or carbohydrate by mouth would only be of use in the early stages of any hypoglycemic attack.

Oral hypoglycemic agents may also cause minor attacks of hypoglycemia. Again, the type of shock may depend on the speed of decrease in the blood sugar and the dosage of the agent. However, due to a tendency to euglycemia, shock is not as common as with insulin.

Regular insulin or globin insulin are less likely to cause serious symptoms affecting the central nervous system. With these two insulins, the sympathetic nervous system usually gives warning first. However, exceptions do occur, and other systems, especially central nervous and vascular, may be directly involved.

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4. Case No. 1288, April 1961.

VISUAL REPORT

Highlights of the scientific exhibits, lectures and panel discussions of the AMA's 110th Annual Meeting in New York City are available on a 33 minute sound film issued by the Schering Corporation. County Medical Societies may obtain copies by writing to the AMA in Chicago.

Delaware Academy of General Practice

George J. Boines, M.D.

The American Academy of General Practice has proven the value of postgraduate training for its members over the years. The Delaware Academy of General Practice has striven to keep up with the requirements of the parent organization by offering its members well-organized and current courses to attend each year.

In order for a general practictioner to maintain his membership in the state and national organizations, he must furnish proof that he has attended at least 150 Category I credit hours of approved graduate studies during each three-year period.

This year we began our program with a one-day seminar on antibiotics, held April 8 at the Academy of Medicine. Attendance provided 6 hours of Category I credit. Co-sponsored by the DAGP and The Pennsylvania Hospital Continuation Education Department, the seminar discussed all the major antibiotics in detail, including matters of toxicity, indication, and the particular drugs which proved to be most effective when used for various specific infections.

A valuable adjunct to the seminar was a detailed outline given participants detailing the value of making gram stains of the patient's infection as soon as the infection is suspected. This requires only a few minutes to perform and reveals to the physician the type of organism predominating, such as rods, gram positive or negative, cocci, etc. This information enables the physician to order immediate therapy, rather than wait several days for a culture. The lecturers discussed which antibiotics were found most effective for each group of organisms.

The main fall postgraduate course is on internal medicine in office practice. It is sponsored by the Delaware Academy of General Practice and Hahnemann Medical College of Philadelphia. This comprehensive program will be given on 10 consecutive Wednesdays from 2:00 to 4:00 p.m., starting September 13 and ending November 15. The subjects to be discussed will be Cardiovascular Disease — Auscultation of the Heart; Fluid and Electrolyte Balance in Medical Practice; Cardiovascular Disease —Laboratory Diagnosis of Heart Disease; Hypertension, Diagnosis and Treatment; Radioisotopes—Their use in Diagnosis; Neurology—The office Neurological Examination; Rheumatology—The Analysis of Synovial Fluid in the Diagnosis of Rheumatic Disease; Rheumatology—Fibrositis and Cervical Root Syndromes; Endocrinology—Office Practice of Endocrinology. Each session will include a question period from the floor. The lectures are open to all physicians.

The final postgraduate session of the Delaware Academy of General Practice for 1961 will be held on the first Saturday in December, when the Scientific Session of the Annual Meeting will be held. It will be followed by a dinner and a dance in the evening. All physicians will be invited to attend.

SOME NOTES ON GROUP PSYCHOTHERAPY FOR SEVERE MENTAL DEFECTIVES

• **An experimental study with a group of nearly inarticulate individuals attempts to learn whether therapy can be effective without verbal insights, free associations and interpretations, which are the "sine qua non" of traditional psychotherapy.**

EDWARD TAVRIS, Ph.D.

Introduction

The purpose of this paper is to describe the dynamic forces in operation in a group psychotherapy setting presently in operation in a hospital for the mentally retarded. Dynamics, in this instance, refers to such factors as composition of the group, relationship of the members to each other, social millieu of the therapeutic setting, and physical setting of the therapy room, to mention only a few of the factors which vitally influence the character of this complex entity, known as psychotherapy. Last, but assuredly not least, will be an attempt to evaluate the effectiveness of the therapeutic processes in terms of its various outcomes, both objective and subjective, which (we have faith) are indicative of improvement in mental health, or adjustment.

Valid evaluation of the therapeutic outcome is, under the best of conditions, often hazardous and tenuous. Mental health is not susceptible to many of the objective measurements which characterize the methods of physical medicine. Body temperature, blood composition, heart beat, etc. are all signs which "speak" to the doctor and give him detailed information concerning the physical state of the subject. The psychotherapist, on the other hand, must rely largely on the subjective feeling of the subject to supply him with essential data. True, the therapist also considers many of the patients' behavioral characteristics as indicative of adjustment or maladjustment, but these are often difficult to interpret. Often, aggressive behavior, which has a negative meaning of itself, is a positive indicator of mental health strivings, just as a fever accompanying certain types of illness often reveals that the crisis has been resolved. Ultimately, in classical psychotherapy, the subject needs to verbalize his feelings of well being before the therapist can have some measure of confidence that the therapeutic process has been effective.

Psychotherapy with the mentally retarded has some limitations not inherent in working with the intellectually normal. The

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process whereby the subjects secure insights through verbal communication is next to impossible, because their language facility, and consequently their ideational capacity is so impaired that they cannot communicate their ideas to others, even if these ideas are somehow grasped, however weakly, in some conceptual framework.

Nevertheless, as influencial forces in the institutional society, we need to have some available yardstick against which to measure "progress, adjustment, mental health" or whatever other term we may use to describe the process by which an individual integrates (or fails to do so) into his environment. Some of the criteria which we use to evaluate psychotherapy are as follows:

A Reduction of Anti-Social Behavior

We recognize that anti-social behavior is a symptom of deep personality disturbance, and as a symptom it is rarely effective to attack its manifestation directly. Other things being equal, when we merely prohibit the expression of certain behavior, without treating the causes for the individual's maladaptive functioning, we do little to aid him in the adjustment process. Indeed, in many cases, anti-social behavior is a positive step toward mental health. This is particularly true when the state which preceded it was one of antipathy toward, or withdrawal from, the environment. If, on the other hand, a reduction in anti-social behavior is a result of increasing the individual's apportunities for self expression, expanding his environmental horizon, or allowing him to establish satisfying social contacts, we may assume the reduction signifies a positive mental health approach.

Reaching Out to One's Environment

A prerequisite for all growth, physical, mental or emotional, is the tendency of the individual to become increasingly aware of the forces in his environment, and to reach out to them, as well as to adapt and organize his inner world to correspond with what he finds outside. When this fails to occur in the development of the individual, it is a source of primary maladaptation. This is not the place to go into the many possible causes for this primary egocentrism, but only to state that the tendency of the individual to reach out, no matter how undifferentiatingly, is always a positive indication of mental health striving. It is, furthermore, a necessary pre-condition to its establishment.

Improved Test Performance

It is necessary to look at test performance in two ways in order to appreciate its significance in the adequate evaluation of the individual. In the more common method of appraisal we look upon improvement in test performance as a direct representation of improvement in personal functioning, much as a medical practitioner looks upon a graph bearing an EKG record as evidence of how the heart is behaving. This is often unfortunate, because there is rarely such a direct relationship between test performance and psychological structure as there is between a laboratory test and its psychological correlate. There are, in other words, more intervening variables that exist between a laboratory test and its psychologi- its meaning, than there is between a high white blood count and its significance. I am not saying here that laboratory tests are used in isolation, (separated from consideration of the whole patient) but only that the relation of laboratory finding to diagnosis is more direct in physical medicine.

The second method of looking upon improved test performance involves a focusing of attention on the release of blocking, or inhibiting tendencies which allows the individual to function more effectively. It is too frequently the case that various professional personnel look askance at greatly increased IQ scores from one testing period to another, believing that, either the subject's IQ has "improved" from one period to the next, (thus discrediting the psychologist's view of the constancy of the IQ) or, great errors have been made in one or the other test administrations. It is important, I believe, not to reify IQ's (and consequently not to discredit them when they do not conform to our prejudices), but to understand

them better. Using the IQ score as an example of test performance, the following statements might serve to promote better understanding of its significance:

(1) The IQ is a test score, measuring an individual's performance on a select type of activity, on a certain day, and is subject to all the variable influences of emotional state, physical health, perceptual acuity, motivation, etc. When any of these factors vary (and they are never constant from one day to the next) the performance (and consequently the IQ) varies accordingly.

(2) When the psychologist states that the IQ is relatively constant he refers to the fact that the upper limits of capacity for tests of this nature are fairly rigidly determined. The difficulty evolves from the fact that an individual often performs below his potential, due to a disturbance in one or more of the areas mentioned. In spite of this variability, the IQ does, in fact, retain a remarkable stability from one testing to another.

(3) The IQ is not a fixed number. Testing involves a sampling of activities, and sampling reliabilities have certain ranges of probability within which we may have confidence in the results. The medical laboratory worker uses the sampling technique, perhaps even more extensively than the psychologist, although this fact rarely causes a stir. In counting the white blood cells, for example, a drop of blood taken from the finger is supposed to be representative with respect to the number of white cells in all the blood circulating through the system. Then a certain portion of the slide containing the cells are counted (utilizing approximation methods), the number is rounded off to the nearest 100,000, and this figure represents the number of white blood cells in a cubic centimeter of blood. I am not, of course, presumptious enough to object to this procedure. There can be only one question raised in methodology of this sort, namely, "Does it work?". The blood counting technique is obviously well enough validated to leave no doubt as to its efficacy. In intelligence testing, however, an IQ of 67 is purported to be a fixed and immutable index.

I find that I have strayed from the original point to be stressed here, which is that psychological test data is never translatable by "slide rule" techniques to psychological corelates. They provide only a basis for inference which must be checked and weighed against a number of criteria, and be substantiated or corrected by them. Test response or scores are not psychological equivalents for clinical entities. They may only be suggestive of certain psychological states which need to be validated. Multiple determination is as true in psychology as it is in the physical and biological sciences.

The preceding criteria, namely, *reduction in anti-social behavior, reaching out to one's environment*, and *improvement in test performance*, while not mutually exclusive, may serve as sufficiently stable and objective variables to use in assessing mental health growth.

Criteria Used to Select Members of Group Psychotherapy Class

It would be very informative if a study were done to answer the question of why certain individuals are chosen to receive psychotherapy out of the number of possible subjects. The rationalizations of psychologists, and the establishment of "objective criteria" fail to come to grips with this problem. It is best, perhaps, to accept our prejudicial attitudes, and operate within that framework, than it is to delude ourselves that personal biases were not influential in our selection.

Sexual aberrations may be abhorrent to one psychologist, physical deformities to another, and hostile tendencies to a third. A psychologist may studiously select his cases (unconsciously, of course) so that his success average will be high. Still another therapist may use the subject as a source of ego satisfaction, as many patients transfer their affections to a parent substitute, or other authority figure.

The previous comments lead the way to a discussion of the manner in which the pres-

ent therapy group was selected. While suggestions were accepted and noted from various members of the Hospital's professional staff, the actual selection of the members was decided in a meeting held between the Chief of Educational and Recreational Services, and myself. The following criteria, although not specifically stated, were influential factors in deciding upon the composition of the group.

Need

Although almost all the patients in the Hospital could derive benefit from close personal associations, it was necessary to limit membership to those who showed most disturbances in their interpersonal relationships.

Compatibility of Group Members

The extensive experience of various members of the professional staff in how certain individuals relate to each other, proved to be valuable in reducing the number of possibly explosive situations. I am not advocating the practice of selecting patients who are amiable and cooperative in every way. Since these individuals are primarily disturbed in the area of interpersonal relationships, it is essential that the therapist expose them to situations involving conflict, for the purpose of suggesting new, and relatively stress free solution. Also, it may be pointed out, the presence of the therapist reduces the explosive quality of the disturbance. Nevertheless, the periods between stress and stress free conditions should not be too heavily weighted toward one or the other end of the continuum.

Minimal Functioning Level

While it is my firm belief that all individuals, no matter how disturbed or retarded, can benefit from kindly care, attention and love, the services of the therapist are reserved for those who show indications that they may some day function as productive members of society. Also, without the employment of verbal communication, the psychologist is severely handicapped in his means of treatment. Some subjects are retarded to the extent that they are unable to respond effectively to spoken language. For our purpose in the group psychotherapy program, we stipulate that the individual must be able to respond to verbalization, and to use speech himself, even though inadequately, due to social isolation or structural defects.

Composition of the Group

The members of the group are five in number. Before giving a character and personality analysis of the members, their commonality of traits and status will be discussed.

All members of the group are severely retarded (IQ's under 40), although one of the boys occasionally functions above that level on a standardized intelligence test. They have speech impediments ranging from moderate to very severe. Some of the speech difficulties are largely due to lack of early training, and stimulating environment, while others have their most influential roots in structural defects. None of the boys looks entirely normal, but all could probably be integrated into society without too much disturbance on the basis of personal appearance. None is grotesque looking. They are all ambulatory, but have locomotive peculiarities which are probably more distinguishing marks of their retardation than are their facial characteristics.

Finally, they all have adjustment difficulties, but differ widely in their manifestations. Some conflict openly with society, others covertly. Still others internalize their difficulties. I do not make these distinctions as clearly differentiating characteristics. They exist in different degrees in all the members, but they may serve to emphasize some of the more significant motivational forces in their lives. The members (all white males) are employed on regular work schedules, and are capable of carrying out their duties in reasonably satisfying ways. None is considered capable of learning academic subjects, but they attend training classes where they learn practical and occupational skills. Occasionally they are given exercises in the forming of letters and numbers, but there is little carry over in the learning of

these skills in practical situations. None can read, write, or calculate, although they can remember and reproduce symbols when requested. They all display a need for recognition and acceptance. They all appear significantly younger than their actual chronological ages. It seems as though maturation, in the normally endowed individual, effects a maturation of the facial features, while the slowness of intellectual growth in the hospital population mirrors its influence in the slow development of expressive characteristics. Following will be an attempt to describe the individual members of the group.

John

This is a young man of 21 years, looking, perhaps, five years younger. He has straight blond hair, is rather slim, and somewhat under developed physically. His distinguishing features are his protruding front teeth, a rather meaningless smile which he uses as a means of overcoming his social inadequacy feelings, and a facade of thoughtfulness, which he employs for the same purpose. He is one of the more verbal members of the group. His facility in language is hampered by faulty speech habits. He slurs his words, while speaking too rapidly, and omits parts of speech which give social form to language. He is a social deviant, but not a delinquent, being much too timid to be aggressive against society. He protests in the only way available to him, by "forgetting" the rules laid down. He continually breaks his eye glasses which are bought for him. This behavior serves as a means of protest, and as an act of vanity. He considers himself to be attractive without his glasses. John is a fraud. He likes to appear learned. The achievement of reading and writing skills are of considerable importance to him, and, since he cannot master them in fact, he shams their accomplishments. Many hours can be, and are, spent in a repetitive copying of numbers and letters. He can not, however, name them, nor does he really understand their function. The activity, however, does serve a useful purpose. The ability to sham, and the strength of this goal directed act are positive features of his personality. He is the only member of the group who has occasionally achieved an IQ score over 40. I question whether intensive individual therapy would serve a useful purpose. Emphasis on increasing his skills would, perhaps, lessen his need for gratification by sham. He frequently phantasies that he is loved and protected by his mother who will some day take him home. He also speaks of the jobs he will have, and of the money he will make. The latter phantasy is quite typical of the hospital population.

Jeff

This is a white man of 29 years, physically well developed,with rather even features. From a distance of several feet one might not observe anything out of the ordinary in his features. His emotions, however, color his physiognomy quite strongly at most times. He is quite verbal, and articulates rather well. He could be called pleasant looking, with the qualifications as noted. The most distinguishing characteristic is a marked tendency for him to speak to a person with his eyes focused several degrees to one side of him. This is not a question of shyness, it is felt, but associated with an eye condition of some type. There is a very strong attachment to adult figures which manifests itself in attemps at conversation, and occasionally for physical contact. Sometimes, in the midst of a conversation, he will place his head on the person's chest and say, "I like you". He is outwardly aggressive, with his uninhibited calling out to a persan, and his frank and articulate (although largely meaningless) conversations. He is actually over sensitive, and when one speaks directly to him in terms of reprimand or criticism he may break down and cry. Another peculiarity is his forgetfulness, or apparent forgetfulness. Although the therapy class has been in progress for several months, invariably he greets me with the words, "When I come to ye, huh? I come to ye Monday? What time?" This pattern of questions persists, no matter how long and patiently the date and time of the meetings are given to him. An early intelligence test (when he was 7 years old) estimated the IQ at 41. All tests in the past 5 years estimated the IQ at between 25 and 28.

He is cooperative and friendly. Conversation is generally relevant only to immediate stimuli and/or gratification of immediate impulses. He is unable to converse in any straight lines, or follow a train of thought. His physical status and bearing (except for the visual anomaly previously noted) are superior to his social functioning. He is childlike in his dependence, but superficially forward and aggressive.

Larry

This is a 21 year old white man, rather tall and thin, but physically powerful. His face is strongly marked by acne, which he does not improve by his habits of personal hygiene. He is often seen chewing a plug of tobacco, which practice, he believes, gives him the impression of being a rather worldly individual. He squints his eyes when he speaks to someone, not to effect any visual accommodation, but to enhance the impression of thoughtfulness. His phantasies are patently immature. They are generally of the television cowboy variety, involving persons who deal in violence. There was a period, when, if I addressed him by his name, he

would glare menacingly at me, saying, "Don't call me that. My name is Sundance." His conversation frequently involves narrations about alleged gun battles which he fought with the police, and innuendos of sexual exploits. His speech is difficult to follow, although its origin appears to lie in faulty habit formations, rather than in structural defects of the vocal apparatus. When he is asked to repeat a statement which he makes, he grins contentedly for a while, as though digesting the fact that his train of thought could not be followed.

There are two other facts which should be noted here. At one time he and another young man were involved in the slaying of two small farm animals, which they accomplished by inserting rubber hoses in their mouths, and injecting gas into their abdomens. An investigation of the incident resulted in the sending of the other boy to a home for disturbed adolescents, while Larry was given a lesser punishment. Undoubtedly he was only a follower in the planning of the incident, but his sadistic impulses can clearly be observed. The other incident concerned alleged sex relations he had had with one of the female patients in the Hospital. Both incidents were apparently unplanned, occurring as a result of a need for immediate gratification of his impulses, and were quite in line with his character.

David

This is a short, stocky, well built young man, without obvious physical defects. He is the best socially adjusted member of the group. He can always be depended upon to cooperate with the social demands that are made on him. Affectional need is very strong, but he is able to function without socially deviant behavior. He gives a fairly presentable appearance. His speech is less intelligible than that of the other boys, apparently due to organic involvement. He does not take part in the group discussions unless questions are specifically directed to him. He never voices complaints of any nature. His IQ has, at times, approached the moderate level of retardation, and at other times shown strong regressive tendencies. The wide variability of his tests scores suggests that, because he is unable to externalize his adjustment difficulties, repressive forces disturb his test functioning.

Carl

This is a tall, thin young man of 19 years, who holds an intermediate position in the group with respect to his manner of adapting to his environment. Phantasies do not appear to play a significant part in his life, as they do in Larry's case. He does not thrust himself on to people, begging for their affection, as does Jeff. He is unable to win the recognition of the adult figures in his environment. He has epileptic seizures, which contribute significantly to his uncertain state. It is very difficult to see a dominant motivating influence in his behavior. He speaks little, and what is said is scarcely intelligible. Like the other members of the group, Carl is not unattractive when he is dressed and groomed appropriately.

Therapeutic Principles

Effective group therapy involves re-education. In the relatively controlled environment of the therapy room, social interaction, which in other environments could be explosive and anxiety producing, loses its explosive quality, (through the timely intervention of the therapist) and becomes a possible vehicle for learning more satisfying modes of expression. A common conflict arises when one of the group members tries to raise his status by boasting about how he had controlled a situation.. Someone invariably takes exception to his statements, either by calling him a liar, or by "outdoing" him in bravery, in aggressiveness, or in virility. It would be entirely misleading to suggest that there is any "formula" for transforming a situation of threat and danger to one of amiability and enlightenment. Indeed, this rarely happens. In one instance the therapist might try to make dangerous statements less threatening by making their impacts less predictable.

When the therapist (or any other authority figure) registers disapproval or shock the "game" is played according to the patient's rules, because he is constantly exposed to similar reactions from the inflential persons in his environment, and consequently he knows how to relate to these reactions. If the therapist, on the other hand, indicates that he understands the intent behind the patient's behavior, and responds to it, rather than to the actions, which are merely symptoms, positive influences may suggest to him that his present behavior is not accomplishing his purpose.

The Therapeutic Setting

They boys, five in number, arrive at the therapy room one morning a week, where they are transported by the school bus. They sit in their accustomed places without exception. Although the members understand that they are permitted to talk on any

subject, and state what is on their minds, they invariably look to the therapist for leadership to begin discussions. The therapist begins by asking questions (particularly of the less verbal patients) about past or projected social events, in order to stimulate interest. These questions are generally answered with the greatest of parsimony (in terms of verbal content). There is little social interchange between the members, because they have little capacity to respond appropriately to lines of thought developed by someone else. One member's remarks either have no relation to another's, or they are tangential to them. The therapist here serves the role of the conjunction (in a psychological context) by relating two ideas offered by different members, which might otherwise have no unity.

As was indicated before, verbal insights can have only limited value in the case of these very defective subjects, since they lack the capacity to deal with language effectively. Attitudes, however, are transmitted quite readily on a non language basis, and perhaps beneficial results occur, as a product of their feeling tones being understood and accepted by the therapist. Unlike traditional psychotherapeutic settings, where generalizations or carry-over of specific learning is the rule, such transference is here the exception. The result is that many more specific bonds tying together cause and effect must be established in the severely defective than in the more amply endowed. Mental defectives do not entirely lack the power to generalize, but many more concrete examples of specific instances depicting relationships must be used before there is any understanding of general applicability. Thus, effective therapy must go much farther than the verbal communication of certain principles in the therapy room. It must include more varied forms of experience than are associated with psychotherapy of the normal individual. Part of the time of this group is spent in taking walks to explore the world of nature, to see what other groups of patients are doing, to understand the interdependence of the separate hospital functions to one another. Part of the time is spent in play, to give expression to socially acceptable impulses, or to be productive by creating new forms with play things.

Not all members of the group can be reached with equal facility. Some are too entrenched in their own modes of behavior to seek new ways of responding. Others are so eager to please the therapist that they offer no resistance, and so no change is effected. That is, to say, in order to effect change resistance must be overcome. If no resistance is offered there can be no alteration of personality structure.

Concluding Remarks

It might appear, that with all the qualifications and objections raised in this paper, there can be little improvement expected in the psychotherapeutic treatment of the severely defective. Without the ability to observe what goes on in the minds of these patients we cannot presume to judge, a priori, that they will not improve in an atmosphere of acceptance, understanding and instruction. Carl Rogers, one of the most brilliant of present day psychologists, holds that all individuals, irrespective of their endowment, strive to achieve independence and maturation. Behavior which appears to be motivated toward opposite goals, simply means that we are unable to understand the significance of their actions. We propose to make certain highly pragmatic tests, which we hope, will tell us whether we are proceding in the right direction. Among these tests the following will be included:

(a) Reports of hospital personnel indicating whether these patients are improving in their interpersonal relationships.

(b) Psychological test findings to determine whether they can deal with impersonal problem solving activities more effectively.

(c) Ability to work and learn more effectively at the job and at school.

(d) Observations of the therapist, determining whether, and to what extent, the members of the group are able to function more freely, less defensively, and with a minimum of distortion to the objective features of their environment.

Editorials

MERGER OR CONSOLIDATION?

The highlight of the current issue is the article by Doctor Cannon urging a prompt and thorough study of a possible merger of the three non-sectarian hospitals in Wilmington. Comment on his article was invited from several members of the Society and we are happy to publish the remarks of Doctor Lewis B. Flinn.

Doctor Cannon advocates a merger of the three hospitals. He forsees the medical staffs of the three present hospitals fused into one giant staff while the three present physical plants are used to accomodate patients according to their medical-surgical category. This is more than a merger; it is a consolidation.

Elsewhere, in instances too numerous to mention, hospitals have been merged for administrative purposes into medical centers but, with the exception of psychiatric, contagious, and obstetric units, the hospitals involved usually have retained their autonomy.

The problem admittedly is a large one and deserves further investigation. Doctors Cannon and Flinn have devoted years of service to the hospitals of Wilmington and with men of this calibre interested in the problem, we can be assured of a thorough study.

THE ANNUAL SESSION—1961

President McGee and his committees have arranged an outstanding program of general interest. A morning panel on the collagen diseases brings authorities from Johns Hopkins while the afternoon panel on the latest developments in diagnostic radiology is manned by professors from Pennsylvania, Jefferson, Hahnemann, and Temple. The program is rounded out by individual papers on psychology, technics of cholesterol reduction, and the medical problems of manned space flight. An interesting, authoritative, and brief postgraduate course.

DIABETES DETECTION

November 12 to 18 has been designated as Diabetes Detection Week. During this period, as in the past, physicians with the cooperation of the pharmacists will gladly perform a urinalysis for glucose on any person who desires this test. In the past, cases of unknown diabetes have been discovered.

When any disease is discovered as the result of a screening test, it obviously has been discovered at an earlier stage than if the individual were to consult a physician because of symptoms. Early diagnosis, when followed by early treatment, contributes heavily toward a favorable outlook for the patient. This is particularly true of diabetes.

Periodic health examinations are valuable if they are periodic and if they are complete. Annual examinations are wasteful in the average teen-age or young adult population; similarly, annual examinations are not frequent enough in an elderly population. The frequency must be determined according to age and the presence of preexisting disease.

Too many examinations are limited in scope by the whims of the patient or, sometimes, the physician. Some people love to have their blood pressure checked but refuse to even discuss a sigmoidoscopic examination.

"Do as I say, not as I do." Too often is the philosophy of the physician. Regarding periodic health examinations, the physician should lead the way. By so doing he will not only set an example for his patients but will personally reap the benefits which could include early diagnosis and increased life span.

President's Page

"MEN OF MEDICINE"

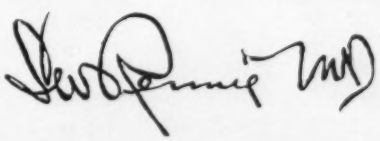
A short time ago I read the Presidential Address of the doctor elected to the office in one of our southern states. He remarked that 50 per cent of that state's physicians did not know who had been elected and some did not care. This indifference bothered him.

It is a fact that physicians, as well as everyone else, must fight the greatest foe in the world today; call it apathy, indifference, carelessness, self-satisfaction, or what you will, it is the attitude of one who feels it would be in vain, or does not want to be bothered, or that there is no need to make an effort to overcome this state of mind.

Indeed the words of Demosthenes written ages ago might almost apply today. "It seems to me, *Men of Athens*, that you have become absolutely apathetic, waiting here dumbly for the catastrophe which is about to fall upon you. There you sit, observing the disasters that overwhelm your neighbors and taking no measures for your own defense, nor do you seem conscious even of the elaborate methods by which your country is slowly being underminded."

I am sure we do recognize the disaster which seems to be approaching. The endless repetition of insults, the implied slander which our profession hears today, tells us in no uncertain terms that there is still a long fight ahead of the medical profession. But too many of us are apt to feel there is nothing to be done about it.

To attack each problem as it arises again, with intelligent planning and with fresh energy and enthusiasm and without a doubt of winning in the end, is not easy but it is the attitude which will help our way of life above all others.



In Brief

Legal Pilot Project

Interest in the rights of the mentally ill has led the American Bar Foundation to publish a book entitled *The Mentally Disabled and the Law*. The preparation of this book pointed up the need to develop more information on how the laws were working in practice. The practical problem of how people get in and out of mental hospitals was chosen as significant for field research. The present project, started on March 20, 1961 in the metropolitan area of Chicago has been followed by intensive surveys in five other areas. Delaware has been included in the Philadelphia-Pennsylvania area which will be surveyed October 25 to December 21, 1961. The survey hopes to show what should be done in order to facilitate getting mentally ill persons in and out of treatment facilities.

Active Duty

Ordered to active duty on October 15th in the 116th Surgical Hospital (Mobile), Delaware National Guard were Drs. Allen C. Wooden, Commanding Officer, Nathaniel Young, John J. O'Connor and F. Barton Wells. They have been sent to Fort Campbell, Ky. Dr. Young, medical director of Emily P. Bissell Hospital, will be replaced by Peter R. Walsh, M.D., who will be acting-director until Dr. Young returns. Dr. Walsh, who came from England a year ago to be assistant director, is an internist.

The Heart Of The Matter

To determine how much cholesterol causes heart trouble, the National Heart Institute is starting a mass experiment involving as many as 400,000 Americans. The program, covering five years, will be composed of men divided into 5 groups: Group No. 1 will be controlled and observed on a diet of foods available in super markets; Group No. 2 will just be observed and not told how to diet or what to eat; Group No. 3 will receive a normal food supply from the Institute every 10 days, controlled by the Institute and watched; Group No. 4 will receive foods from Institute supply houses consisting of "manipulated foods" specially made with all the animal fats replaced by other fats. All five groups will be examined every 3 months with special emphasis on heart condition, amount of animal fat, exercise, and amount of cholesterol in the blood. This experiment grew out of a Congressional request for more specific information on cardiovascular ailments and their causes in this country.

Dependents' Medical Care Continued

Continued eligibility for medical care is due the dependents of those service men retained beyond the expected expiration of active duty tours. Since the involuntary extension of these tours becomes effective immediately, the required proof of an extended date for benefit eligibility may not appear on the dependent's Uniformed Services Identification Card (DD Form 1173). Physicians and hospital authorities have been asked to exercise patience and understanding in handling these cases. This request comes from W. D. Graham, Brig. Gen., M.C.

Personal Glimpses

Drs. Albert Gelb, Wilmington and Paul A. Stagg, Dover, A.F.B., were inducted as Fellows of the American College of Surgeons on October 5th . . . Thomas R. Brooks, M.D., lectured at a meeting of the B'nai B'rith for the American Cancer Society . . . Alfred R. Shands, Jr., M.D., addressed the Wilmington Lions Club on cancer . . . Howard Wilk, M.D., was named surgeon for the city Bureau of Fire by the directors of Public Safety, Wilmington . . . Lawrence C. Baker, M.D., was elected president of the Kent County Unit, Cancer Society; M. H. Mires, M.D., was elected vice-president; and George Campana, M.D., a new director . . . James E. Marvil, M.D., was elected president of the Sussex County Unit, Cancer Society, succeeding Aubrey C. Smoot, M.D.; Leslie M. Dobson, M.D., was elected chairman of professional education and James Beebe, Jr., M.D., chairman of professional services . . . Drs. Lawrence C. Baker and James R. McNinch were cited by the board of directors, Kent General Hospital, for filling in on *all* emergencies for two weeks . . . J .Richard Durham, M.D., spoke on the effect of stress and shock on heart disease to members of the National Association of Compensation Claims Attorneys . . . Drs. Elizabeth and Edgar Miller showed films on their work with the Nepal natives at a meeting of the Woman's Society, Centenary Methodist Church . . .

Joseph W. Abbiss, M.D., president of the medical staff, Memorial Hospital, addressed the recent graduating class of the hospital's School of Nursing . . . Michael Elyan, M.D., pediatrician interested in the multiply handicapped child, addressed a meeting of the Rehoboth Beach Village Improvement Association . . . Drs. Philip J. G. Quigley, S. S. Bjornson, Robert Dickerson and Kenneth W. Ehrhart have been named diplomates by the American Board of Pathology . . . Otakar Pollak, M.D., was elected president of the Delaware State Pathology Society; Joseph Casella, M.D., president-elect; Joseph W. Abbiss, M.D., councilor and Donald Howie, M.D., assemblyman . . . Miss Eleanor Bader, physical therapist, who served 11 years as executive director of the Delaware Curative Workshop has been appointed program consultant to the National Society for Crippled Children and Adults . . . George J. Boines, M.D., was named chairman of the consecration committee of the Holy Trinity Greek Orthodox Church . . . Harry J. Repman, M.D., was chief speaker at the Wilmington Civil War Round Table as their leading authority on Civil War firearms . . . J. R. Elliott, M.D., was honored by an informal surprise birthday party by the Laurel Advisory Board, Farmers Bank of the State of Delaware; in addition to his regular profession as a physician, Dr. Elliott has been a bank director and past president of the Sussex County Medical Society, Medical Society of Delaware and president of the Laurel Board of Education . . .

Another Black Mark

Nictotine from smoking may stimulate the nervous system and the adrenal glands to release a form of adrenalin that frees fat from storage areas in the body, researchers suggest in the American Heart Association's *News Letter*. This could explain why smokers have higher levels of cholesterol in their blood, which in turn is suspected of contributing to heart disease by clogging and narrowing arteries.

Auxiliary Affairs

On Friday, September 9, 1960, the Women's Auxiliary to the Sussex County Medical Society was the hostess county to the Women's Auxiliary to the Delaware State Medical Society. Coffee was arranged and paid for by our county auxiliary. Luncheon arrangements were made by Mrs. Leslie Dobson. The coffee, meeting, and luncheon all were held at the Dinner Bell Inn at Rehoboth. On behalf of our county, Mrs. James Beebe, Sr., entertained at tea the same afternoon.

The following month we had an informal program on legislation. At this time we were urged both to work for and to back the candidate most in harmony with the physicians. We later heard a report from the state president concerning the National Auxiliary meeting in Chicago, Illinois.

We began the new year with a white elephant sale. Many different items were brought by our members to this sale including antiques, china, surplus Christmas gifts, crystal and ceramics. Lively bidding resulted in an evening filled with fun, plus a greatly enhanced treasury.

Early spring brought with it a meeting on the subject of Civil Defense. A program was prepared by Mrs. Thomas Tobin. We were inclined to feel that we were not equipped to cope with a military disaster. This subject seems to have become increasingly important, even since early spring and should be approached again by our auxiliary this fall.

All of our meetings are evening meetings and most of them have been followed by a social hour. We are joined by our husbands at this time and our greatest annual project is the furthering of close comradeship that exists between the medical families in Sussex County.

Auxiliary officers for the coming year are: Mrs. Robert Lewis, President, Seaford; Mrs. Donald Howie, Vice President, Milford; and Mrs. Wildberger continuing as Secretary, and Mrs. Tormet continuing as Treasurer.

Mrs. Aubrey Smoot, Jr., President 1961-62

WOMAN'S AUXILIARY TO THE NEW CASTLE COUNTY MEDICAL SOCIETY 1961-62

Officers

President	Mrs. E. T. O'Donnell
President-elect	Mrs. G. Barrett Heckler
Vice President	Mrs. Alfred E. Bacon
Secretary	Mrs. Haynes B. Cates
Cor. Secretary	Mrs. George N. Eriksen, Jr.
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Mrs. John F. Hynes Mrs. Leslie Whitney
Mrs. Joseph Davolos

Chairmen of Standing Committees

A.M.E.F.	Mrs. Leslie Whitney
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Bulletin	Mrs. H. Thomas McGuire
Civil Defense and Safety	Mrs. William Johnson
Community Service	Mrs. Herman Rosenblum
Dance	Mrs. James T. Metzger
Delaware State Hospital Fair	Mrs. Morris Harwitz
Hospitality	Mrs. Mark G. Cohen
Health Careers Recruitment	Mrs. James P. Aikins
Legislation	Mrs. S. Ward Casscells
Membership	Mrs. C. Papastavros
Mental Health	Mrs. Thomas R. Brooks
Program	Mrs. Alfred E. Bacon
Publicity	Mrs. John W. Alden, Jr.
Public Relations	Mrs. Charles F. Richards
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Or ROBAXISAL®-PH (ROBAXIN with Phenaphen®) — when anxiety is associated with painful skeletal muscle spasm.

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Phenacetin 97 mg. Hyoscyamine sulfate 0.016 mg. Phenobarbital (1/8 gr.) 8.1 mg.
Supply: Bottles of 100 and 500 green-and-white laminated tablets.

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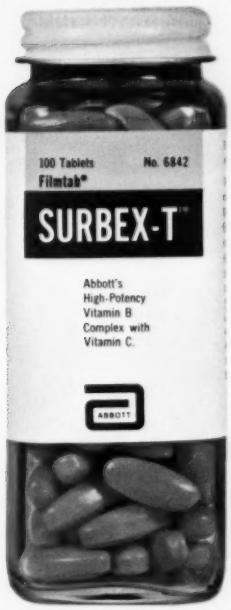

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Thiamine Mononitrate (B_1)	15 mg.
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Cobalamin (Vitamin B_{12})	4 mcg.
Calcium Pantothenate (as calcium pantothenate racemic)	20 mg.
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Liver Fraction 2, N. F.	75 mg.

Supplied in bottles of 100 and 1000

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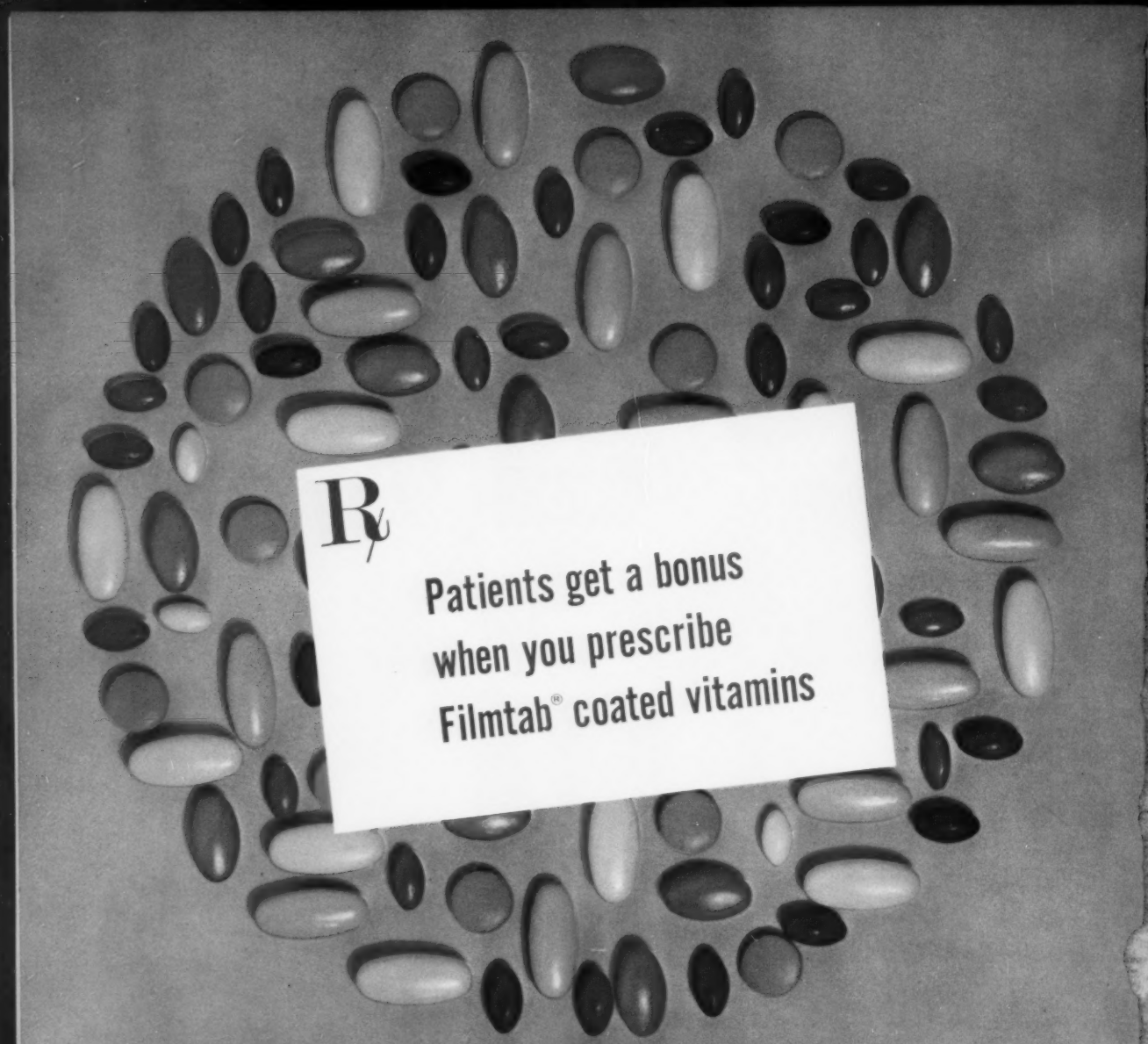
... and, when need is modified, **SUR-BEX with C**, Abbott's improved B-complex formula with 250 mg. of C.



No water is used in the Filmtab process. Potency is enhanced as there is virtually no chance of moisture degradation to nutrients. Shellac sub-seal barriers are not needed or used.

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In short, while good formulas may be similar, formulations *do* differ. Filmtab coatings can often furnish a logical basis for choice.

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B-complex with C formulas
Surbex-T™
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relieve U.R.I. distress rapidly

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salicylamide	0.19 Gm.
phenacetin	0.13 Gm.
caffeine	30 mg.
methamphetamine hydrochloride	1.25 mg.
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For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, N. J.

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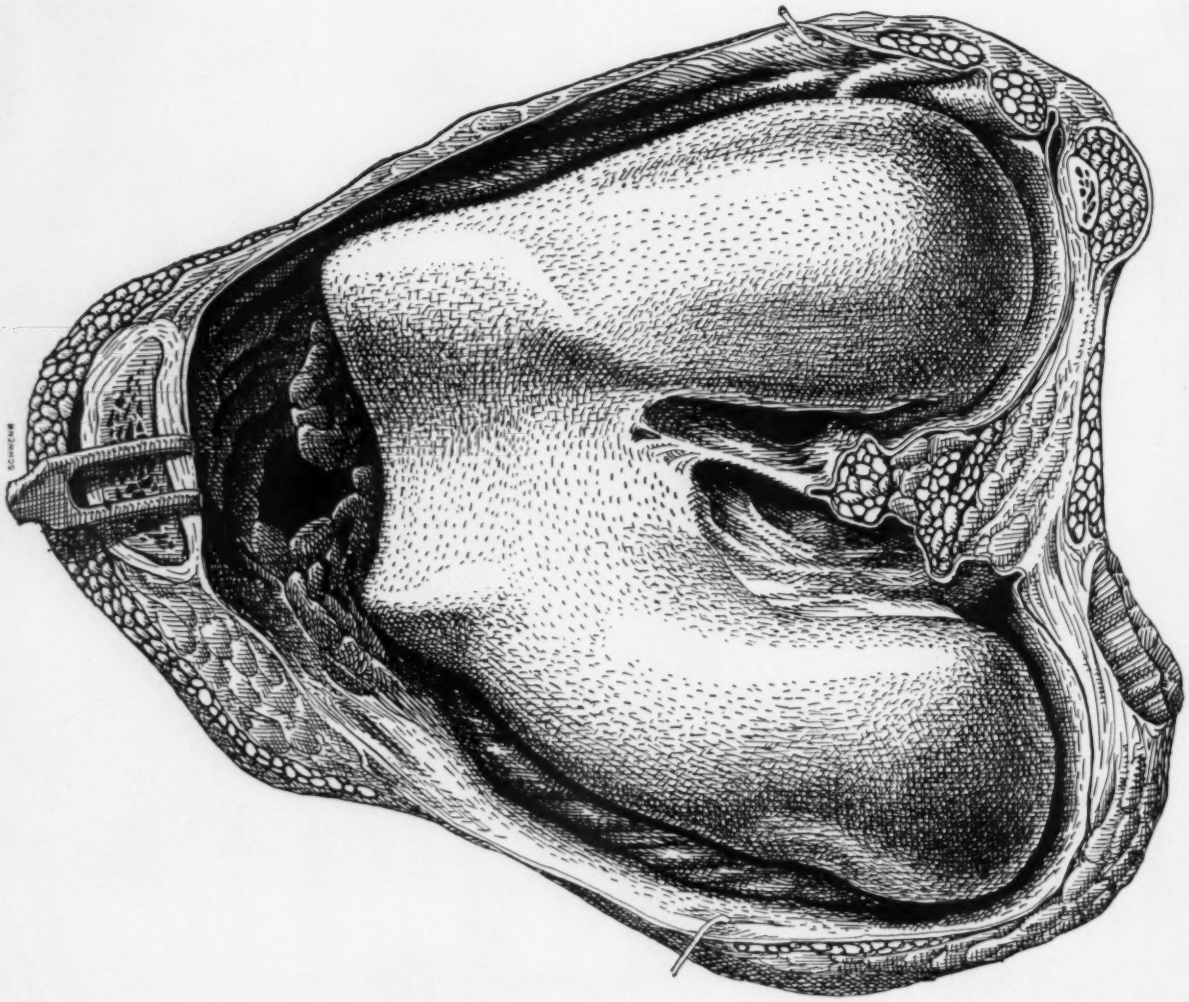

because patients are more than arthritic joints... controlling inflammatory symptoms is frequently not enough!

Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheumatoid symptoms. But a patient is more than the sum of his parts – and the joint is only part of a whole patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for the symptom may also be bad for the patient.

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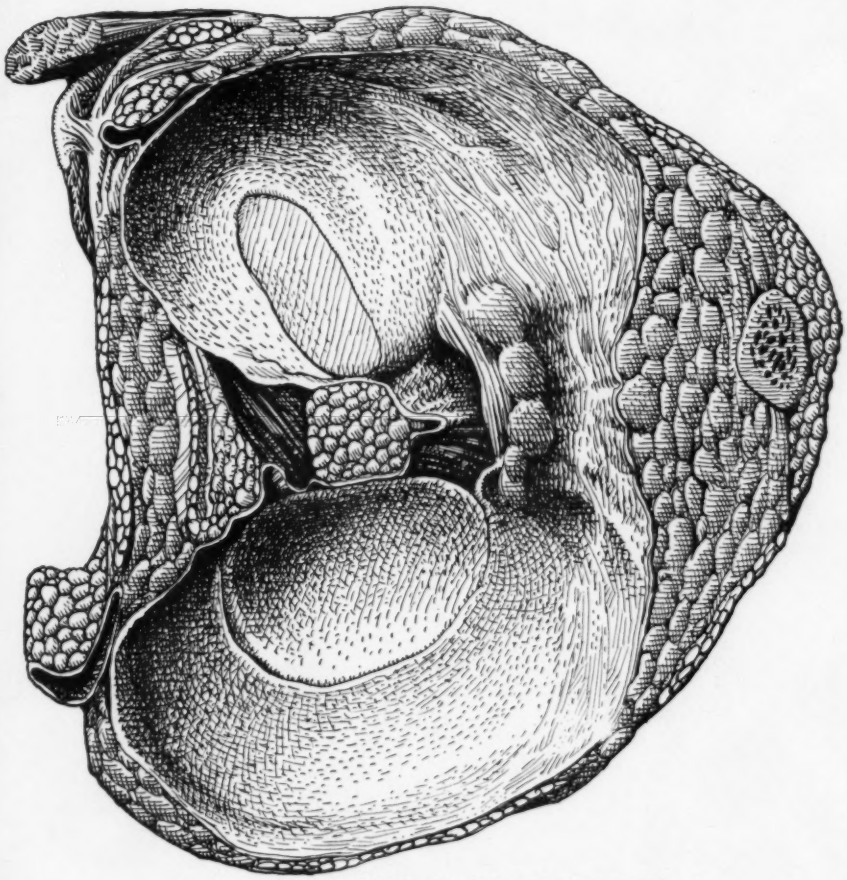

(Knee Joint, Left: distal end of femur; Right: proximal end of tibia)

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ARISTOCORT provides unsurpassed anti-inflammatory control without sodium retention or edema — without the undesirable psychic stimulation and voracious appetite.

Supplied: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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in bacterial otitis media

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In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical.

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Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.

SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.

Urticaria and maculopapular dermatitis, and a few cases of leukopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.

CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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for infants allergic to cow's milk

a modern milk substitute rich and creamy in color, pleasant and bland in taste

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Symptomatic Relief. Symptoms of cow's milk allergy —most frequently manifested by eczema, colic and gastrointestinal disturbances—may be relieved within 2 or 3 days.

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1. Kane, S.: Am. Pract. & Digest Treat. *8*:65 (Jan.) 1957.

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